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MEDICARE CATASTROPHIC COVERAGE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

JULY 11, 1989

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MEDICARE CATASTROPHIC COVERAGE

TUESDAY, JULY 11, 1989

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Baucus, Bradley, Pryor, Rockefeller, Packwood, Dole, Roth, Chafee, Heinz, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-41, June 27, 1989]

SENATOR BENTSEN ANNOUNCES HEARING ON PROPOSED CHANGES TO THE MEDICARE CATASTROPHIC COVERAGE PROGRAM

WASHINGTON, DC—Senator Lloyd Bentsen (D., Texas), Chairman, announced Tuesday that the Finance Committee will hold a hearing on proposals to address duplicate coverage under the Medicare Catastrophic Coverage Program and to consider making the program voluntary as originally approved by the Senate.

The hearing will be held on *Tuesday, July 11, 1989 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

"The Medicare Catastrophic Coverage Act of 1988 included provisions that were intended to assure that Medicare beneficiaries who formerly received catastrophic insurance protection through employer-based retiree health insurance or privately purchased 'Medigap' policies will not receive duplicate benefits under the New Medicare law and their insurance," Bentsen said.

"This hearing will give the Committee on Finance an opportunity to review the implementation of these protections against duplicate coverage by private employers and state insurance commissioners, and to determine whether further action in necessary," Bentsen said.

The Committee will also consider whether participation in the catastrophic coverage program should be made voluntary.

"The Catastrophic Medicare Bill that I introduced and that was approved by the Committee and Senate was voluntary. If an individual chose to drop Part B—the portion that covers physician fees—he could drop catastrophic coverage at the same time," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, SENATE FINANCE COMMITTEE

The CHAIRMAN. This hearing will come to order. Today's hearings on the issues related to the Medicare Catastrophic Coverage Act of 1988 will address two specific areas. First, many Medicare beneficiaries are concerned that their new catastrophic benefits may duplicate the coverage they're already receiving, either through an employer, or through the purchase of private medigap coverage.

According to CBO, 77 percent of Medicare enrollees had some form of insurance in 1987, including 25 percent entirely or partly financed by employers. Quite understandably, Medicare enrollees do not want to pay additional Medicare premiums for benefits they have earned during their working years or that they will also be paying insurance premiums for.

That is why members of this Committee worked to include provisions in the legislation that protect beneficiaries against duplicate benefits.

Senator Riegle offered a maintenance of effort amendment requiring employers to offer new benefits or lower premiums in lieu of health benefits that are now duplicated by Medicare.

Senator Baucus worked to develop modifications to the Baucus standards for private medigap insurance to ensure that Federally-approved medigap policies do not duplicate Medicare.

Senator Pryor worked to meet the concerns of Federal retirees about duplicate coverage under their health benefits program.

Today, witnesses include representatives of groups that are affected by the protection against duplicate coverage. That includes businesses and unions affected by the maintenance of effort requirement and experts on the issues facing Federal and military retirees.

We are going to hear from State Insurance Commissioners and insurers involved in the changing medigap market. I hope their testimony will help us determine whether further action is required to protect enrollees against duplicate coverage.

Now the second issue we will address today is one on which this Committee unanimously agreed when the original catastrophic illness bill passed this Committee. Under our bill the catastrophic benefits would have been optional in the sense that they would be available to enrollees enrolled in Part B of Medicare which is voluntary.

An individual could drop Part B coverage if he or she wanted to avoid receiving the catastrophic benefits and paying the premiums. Frankly, I do not believe it would be in any beneficiary's interest to do so. Since CBO tells us that Part B alone involves a substantial Federal subsidy to every individual enrolled, even those paying the maximum supplemental premium.

Needless to say, equivalent private coverage with a comparable subsidy is unlikely to be available. Legislation introduced by Senators Baucus, Chafee and Pryor, which would make the program voluntary, as under the original Senate bill, has attracted strong support. Today's hearing will explore that approach.

Now there has been a further development. Early last month we had CBO testify that there was going to be a substantial increase in the cushion above the reserves required to take care of the payment of claims to beneficiaries. As I recall, that original amount was $4.2 billion. We had estimates going all the way up to $9 and $10 billion. My hope then was that we could cut back on the premiums because I did not feel that, in effect, we should be trying to pay for some of the deficit in the budget by a further payment on the part of the potential beneficiaries of catastrophic illness.

I have been advised by CBO, as late as yesterday, that the numbers that they gave us at the beginning of last month are dramatically changing and that the potential cost of the drug benefits has escalated beyond the preliminary estimates, adding substantially to the expense of the program.

What that means to me is, a difficult problem in trying to pair the premiums. I think when you get into that kind of a situation that one of the things we are going to have to look at is the option too of a reduction of some of the benefits. The one that has been the most difficult to estimate and one that was not included in the bill as it came out of this Committee, was the prescription drug benefits. That is where the costs are exceeding the original estimates by a material amount. We do not have hard numbers on that one yet. But hopefully we will within the very next few days.

So as you look at a way to try to adjust this and to make it accomplish the objectives originally intended, and to keep it within a reasonable cost, a serious look has to be taken at the benefits. Obviously, one of those will be the question of prescription drugs part, as to whether or not that should be retained or that should be dropped.

In seeing the order of arrival, Senator Chafee, do you have any comment that you would like to make?

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. First of all I want to applaud you for holding these hearings. These are very important. I have a statement I would like to include in the record if I might.

The CHAIRMAN. Yes, of course.

Senator CHAFEE. There are just a couple of brief comments I wanted to make. As you mentioned, I support making this program voluntary. That, as you know, is the way we originally passed it here—passed it on the floor of the Senate—and then when we got to conference it had to be changed. I will be interested in the testimony we have on the pros and cons of the voluntary aspect of the program.

Second, I believe, Mr. Chairman, that this catastrophic coverage provides a good, solid benefit package for the citizens of the United States. Fifty-six percent of all Medicare beneficiaries will get this catastrophic coverage for only $48 a year. That is $4 a month in addition to their usual Part B premium. Now that in my judgment is a whale of a buy. Another 28 percent will get it for less than $350 a year.

We keep hearing about people paying the maximum supplemental. There are only 6 percent of all Medicare beneficiaries in the United States will be paying the maximum amount.

Today we will examine the issue of duplication of benefits. One of the duplication problems obviously lies in the medigap plans and I am glad we are going to get some information on that today. As you know, when we passed this bill one of the requirements was that the medigap insurers eliminate the duplication. There is serious question as to whether that has taken place. I am looking forward to hearing about that.

The long and the short of it, Mr. Chairman, is no matter how much we do to eliminate the overlap between this program, the catastrophic, and other plans, the duplication on the medigap policies will still exist unless we take some action on that front as well.

So I want to thank you, Mr. Chairman, and I look forward to these hearings.

The **CHAIRMAN**. Well, I would say, Senator, I certainly agree with you that the catastrophic illness bill and that legislation fulfills a very major need for our country when we talk about spousal impoverishment, when we talk about the incredible costs on the catastrophic illness and the wiping out of a family's security. Those are all concerns for us that we've tried to address and that has been a major piece of legislation.

Obviously, as we do with all major pieces of legislation, we review it to see those things that have worked up to expectations and those that are not and some of the concerns that have developed. That is what we are trying to address.

Senator **CHAFEE**. Mr. Chairman, we find in the calls to our office that the elderly indeed have been unnecessarily frightened about this program. When they call in, they think they are going to be whacked with this tremendous tax. They call and it turns out that most of them are not paying any income tax or very modest income tax to start with. When it is explained to them—and it takes some effort to go through and explain the whole program to them—and what they save in the medigap, they go away thinking, well this is different from what I have been hearing on the television and elsewhere from some of the senior citizen groups.

I hope we can clarify and clear up some of these misunderstandings in today's hearings.

The **CHAIRMAN**. Thank you.

[The prepared statement of Senator Chafee appears in the appendix.]

The **CHAIRMAN**. Senator Pryor.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator Pryor. Yes, Mr. Chairman, I want to also join with Senator Chafee in thanking you for holding this hearing. Especially, Mr. Chairman, I want to express my appreciation to you for bringing up the very recent, I think as of the day before yesterday, Congressional Budget Office report on the new costs that they are predicting for the programs. The CBO, it is my understanding—I have not read in detail the report, but it my understanding they say that these costs are rising because of the manufacturers price increases and too because of the proliferation of the new drugs that they are bringing to the market at this time.

One, we do not know how many of those new drugs are necessary or whether there is a constructive benefit for bringing this huge number of new drugs on the market. But I think we need to know that answer. On next Tuesday, Mr. Chairman, in the Senate Special Committee on Aging—I will chair a hearing on these points. One is to why there is such a tremendous increase in drug pricing. Two, who is at fault. We will discuss the tiering and the variation of prices charged by the pharmaceutical manufacturers. And finally, we will address who is going to pay the bill.

I would say to Senator Chafee, even though as he said there is an unnecessary frightening of the senior citizens out there, I also maintain—I say to my good friend and colleague, there is an unnecessary, let us say, overcharging to the senior citizens, and ultimately to the American taxpayer for these drugs that the pharmaceutical manufacturers are charging. We are going to try to get to the bottom of this and we are going to have at least two hearings on this. They will begin next Tuesday.

Mr. Chairman, I hope that these hearings will benefit this Committee in ascertaining some facts and figures that we can use in coming to grips with this problem we have before the Committee and others today.

Again, I want to thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Senator Baucus, do you have any comments?

Senator Baucus. I have no statement to make, Mr. Chairman. Thank you.

The CHAIRMAN. All right.

Well, let me state once again that as we look at these and try to see where the increased costs are taking place, that I think we have to take a serious look at the benefits and prescription drugs would be one of those that we would look at, not necessarily just that one.

Senator Pressler, would you like to testify this morning.

STATEMENT OF HON. LARRY PRESSLER, A U.S. SENATOR FROM SOUTH DAKOTA

Senator PRESSLER. Thank you very much, Mr. Chairman. I shall be fairly brief because I know you have many witnesses. I first want to commend you for your leadership in this area and the difficult issues that we must resolve. I also want to commend Senator Pryor, the Chairman of the Aging Committee, for his leadership on the cost of drugs issue. I understand he will be holding some separate hearings on that issue, and as a member of the Senate Aging Committee I am glad to lend my support.

Recently I held some meetings in my State, as many of my colleagues do in their own States, and had large turnouts on this catastrophic coverage act financing issue. I did a survey among those present and others, and although I do not claim it to be scientific, I found a great desire for change in this area. Our citizens are asking that we reexamine this, as this Committee is doing, and I commend you for it.

The survey of my South Dakota senior citizens indicated that greater than 50 percent would like the system changed or implementation delayed. The second highest percentage want to make participation in the program voluntary. The survey indicated that they want a separate category for the catastrophic program. The elderly do not want the catastrophic provisions included under Part B. According to the survey, Part B of Medicare should be left as it now stands.

The benefit of greatest value to senior citizens is perceived to be the spousal impoverishment provisions. Senior citizens view the current premium as far too excessive for the benefits provided. The cost of the catastrophic program is a burden paid by too few people. If coverage remains the same, in their view, a different method of financing must be devised.

The provisions of the catastrophic program already are available to many senior citizens through their supplemental insurance programs. They feel that there's duplication and ask how we can justify the excessive price tags on benefits so few people will enjoy. For example, how many people will use 365 days of hospital care in a year? In order to remain in a hospital and collect Medicare reimbursement, the individual must show continuous recovery progress. Someone who requires 365 days of care normally does not demonstrate a steady recovery.

Second, the nursing home provisions available through the catastrophic program are limited. A nursing home must offer skilled care and be certified by Medicare. In South Dakota I am aware of only four homes in the entire State that accept Medicare eligible residents. I am confident that other States can identify a similar situation.

If we really want to help people who need long-term care, then let us talk about long-term care insurance. There is a definite need to finance extended care. Many South Dakotans who have communicated with me have mentioned this need.

Mr. Chairman, I have additional material here, but I shall summarize my statement by saying that, based on the hearings I have held in my State and based on the surveys I have conducted, our people want implementation delayed; they want a voluntary option. They feel strongly that the price of drugs is unfairly high. They also feel strongly that this is the first time we have had a program benefiting a small number of people who benefits have been paid for by a certain age category of our population. They argue strongly that if we are to have such a program, it should be financed by all the people, not just a small group.

Mr. Chairman, I ask unanimous consent to present the Committee a summary of the survey I took. I thank you very much for the time.

The CHAIRMAN. Thank you very, Senator. We would be pleased to do that.

[The survey and prepared statement of Senator Pressler appear in the appendix.]

The CHAIRMAN. Senator Graham.

STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman, and members of this Committee. I appreciate the opportunity to appear before you today, and I commend you for the outstanding leadership that you have provided to the development of an intelligent policy of health care for older citizens in this country.

The CHAIRMAN. Thank you, sir.

Senator GRAHAM. It was less than a year ago that the Catastrophic Care Act was approved. In less than that year some have now suggested outright repeal. I do not share this view. I believe that there were many positive dimensions to this legislation that should be retained.

However, there have been enough legitimate questions raised that we need to delay portions of this legislation to explore questions, such as the duplication of coverage, the possibility of excess revenue, the financing mechanisms, the question of mandatory versus voluntary participation, and whether this legislation might hinder progress towards a shared goal of long-term care.

Therefore, Mr. Chairman, I support a reasonable period of delay in the Medicare portions of catastrophic coverage. I would define "reasonable period" as 1 to 2 years. During that period we should continue with the Medicaid portions of the legislation, particularly those that relate to spousal impoverishment. We should create a commission to explore health care issues for the 1990s to look at the complex interconnection of public and private health programs, to look at what is happening at the State level, and how we might draw from the experience of State innovations for national health care policy.

To deal effectively with these concerns we must not limit ourselves to the specific aspects of catastrophic coverage. We must set our overall direction in the coming years on how to deal with the relationship between the private sector and public sector insurance, how to bridge the gaps that exist between Medicaid and Medicare and how we find the means to provide long-term care.

These are very difficult and complex issues that can best be addressed with a suspension of the catastrophic coverage and a broad look at our future direction in health care for retirees, a topic of which catastrophic coverage is only a part. We have learned from the debate over catastrophic coverage that there is an intricate web between private and public health insurance programs. One reason we need to delay catastrophic coverage is to look at the problems of duplicated coverage that exist within the current program.

Moveover, we need to look at what private insurance does best and what public insurance does best as we look to the future development of a health insurance system. The strength of the private insurance system is the number of options that can be offered to the consumer. The strength of the public insurance system is the universality of coverage. Because of these different strengths, there is an important continuing role for medigap policies that supplement the core coverages provided by Medicare.

Portions of the catastrophic act have been very positive. For instance, providing incentives for mammography screening will save lives because we know the benefits of early detection in fighting cancer. Prevention of illness protects lives and saves money.

Mr. Chairman, this movement towards a prevent strategy, manifested by the mammography provision, is a step in the right direction. The Medicare system and the rest of our health network, including the Veterans Administration, should emphasize prevention as well as treatment.

Another positive aspect of last year's catastrophic legislation is that it addressed the problem of retirees who did not qualify for Medicaid but could not afford medigap private coverage. The surtax on retirees who pay income tax does not seem to be an appropriate way to finance this solution, but the problem still needs to be addressed.

We have learned from the debate over catastrophic coverage that long-term care is the major goal of most American retirees. My fear is that catastrophic coverage, by creating additional resistance to new financing mechanisms, could be an impediment to establishing coverage for long-term care. Long-term care is an extremely complex issue. Congress and the American people should explore all methods of providing services and financing those services, including public support and incentives for private insurance to provide complimentary services.

Mr. Chairman, there are some exciting things happening at the State level that could give us direction. In the State of Washington, a sliding scale has been developed in which the State is assisting those persons with low income to purchase private insurance to cover some of the costs of long-term care. In our State of Florida we have developed a community care for the elderly program, which attempts to provide a range of services related to the desire of older persons to maintain independence. But as the aging process limits that ability, there are complimentary, publicly funded services.

These and other initiatives, I think, can be looked at for ideas and innovations that could be incorporated at a national level. Delay of anticipated reforms is never a pleasant prospect. But the problems of catastrophic coverage and the other issues discussed earlier are complex and cannot be considered in isolation from each other.

We should delay implementation of catastrophic coverage because we need to develop programs that have the confidence of our retired population. We need to evaluate the direction of health insurance over the next decade to see if catastrophic coverage assists or impedes these developments. We need to think comprehensively and to consider options that in isolation might be misunderstood.

Blue ribbon commissions are not panaceas, but they are useful for taking a broad long-term perspective. I believe that such a commission is an appropriate forum for addressing our 10-year goals in the Medicare system. The delay caused by this approach is justified by the impact of our eventual decisions on the lives of all Americans.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Would that include, when you talk about delay in Part B, would that include also a delay in mammography?

Senator GRAHAM. Yes. I would propose that we defer all of the Medicare aspects of the catastrophic legislation. I would exclude from that delay the Medicaid provisions.

The CHAIRMAN. Thank you.

Are there questions of the Senator?

[No response.]

The CHAIRMAN. Thank you very much, Senator.

Senator GRAHAM. Thank you.

The CHAIRMAN. I see the minority leader has arrived. Senator Dole, would you care to make any comments?

OPENING STATEMENT OF HON. BOB DOLE, A U.S. SENATOR FROM KANSAS

Senator DOLE. I would just make a short statement and I would ask that my statement be put in the record.

The CHAIRMAN. That will be done.

Senator DOLE. I want to first congratulate the Chairman for these hearings and my colleagues from both the House and the Senate who have been testifying and other witnesses who are certainly knowledgeable in this area.

I think it is fair to say that participation in Medicare should not be viewed as a burden. However, I think there is the perception out there because of some features of the Catastrophic Bill that this is a burden. We have added new benefits and frankly they maybe a mixed blessing. We have recently had the opportunity to debate this issue on the floor.

I also want to congratulate Senate McCain along with other colleagues on both sides the aisle for alerting us to some of the real problems. Certainly, Senator McCain has been the leader in that effort.

We are trying to figure out what we should do. I mean some of us would like to hang onto this program, but make changes that are necessary to remove some of the inequities. Some of the inequities have been addressed by the Chairman earlier in his opening remarks and were addressed by the Chairman weeks ago when they were called to his attention. We do have duplication of coverage and it is an area that we ought to address, whether its a problem for military retirees or Federal employees.

Frankly, I think there are different views about what we should do. I guess we could say that some would like to replace the supplemental premium with general revenues but we do not have any surplus in general revenues. It seems to me that there is a very basic principle in this catastrophic law with respect to financing that I think has merit, though those who pay it obviously do not share that view.

However I think we should return to the position taken by the Senate at the time of the passage of the bill and link participation to Part B so it is voluntary. In fact, if the benefits are as good as—many argue they are—then people will choose to be covered. In my view, people have the right to make a choice.

With respect to the bigger issue of the size and the structure of the premium, the jury is still out. In fact, if a surplus truly exists, adjustments should be made. But again, I understand that surplus may not be as great as previously indicated. However, if we find that we do not have a surplus and there is still dissatisfaction with the program, perhaps the next step should be to review the benefits themselves.

I, for one, believe that we have taken on more than was necessary and more than we could handle. The respite benefit certainly is an example. I remember, I think the price tag was about a billion dollars. I remember during the conference negotiation I was told by the HHS Secretary that the Administration was opposed to it, so I wrote letters to everybody saying we're opposed to it and the next thing I knew the Administration capitulated.

The drug benefit, is another example, certainly a lot of people wanted it, but I think there are some that believe we ought to take another careful look at—the drug benefit and respite care.

If this catastrophic program is too costly and we want to preserve the basics of it, then we have to start taking a look at some of the benefits where we may have gone too far. So I want to work with the Chairman, Senator Packwood, and other members of this Committee, and my colleagues in the Senate so we can avoid the rather fractious battle we had on the Senate floor the last time this issue came before us.

I commend the Chairman for trying to work out something we can all live with.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Dole appears in the appendix.]

The CHAIRMAN. Senator McCain.

STATEMENT OF HON. JOHN McCAIN, A U.S. SENATOR FROM ARIZONA

Senator McCain. Thank you, Mr. Chairman. Thank you for again giving me the opportunity of appearing before this Committee on this very important issue. I would like to thank you again, Mr. Chairman, for your efforts at trying to reach an equitable solution to what has become a very, very difficult issue for members of the Senate and members of Congress and the American people.

Mr. Chairman, there is no doubt that the intensity of the opposition to this legislation continues to mount and some action needs to be taken. To start with, Mr. Chairman, I would like to put to rest, I hope finally, something that has been a great concern to me and that is the allegation that was made time after time on the floor of the Senate that seniors are just a bunch of greedy malcontents who are not willing to pay for their own health care protection needs.

Mr. Chairman, that is not the case. The bill that I have sponsored, which was offered as an amendment to the Supplemental Appropriations Bill, is supported by 44 organizations representing 19 million seniors—organizations like the National Association of Retired Federal Employees, the American Postal Workers Union, the National Association of Government Employees, the National Association of Letter Carriers, Naval Reserve Association, Federal Postal Workers, and many others. Mr. Chairman, these are not greedy Americans. They are not rich and they are not greedy.

I hope such accusations will not be part of this debate again. To accuse these people who are opposed to the catastrophic health care bill as it is presently shaped, as being rich and greedy Americans is plain wrong. They are not. They are average Americans who see that a piece of legislation has been passed which provides for benefits they do not need, they do not want to pay for, and does not address the key concern of seniors in this country no matter what their income level—that is long-term care.

Mr. Chairman, seniors know what their needs are. They are angry because they are being forced to pay for some expensive things they feel they don't need as much as long-term protection. You are right, Mr. Chairman, providing any long-term protection will be very expensive. That is because the care itself is expensive. We all know that it costs about $25,000 to $35,000 a year for nursing home care. Seniors fear long-term care and its costs. They know that private insurance for long-term care is very expensive, and in many cases they cannot even get it.

In spite of these realities, we adopted legislation which consumes a lot of the seniors' resources to expand acute care coverage. The very passage of this act may preclude us from doing something about long-term care for a long time to come. And, seniors know this.

Let me repeat with some fear of redundancy, Mr. Chairman, what I have proposed is to delay for a year the implementation of the portion of the Act which has yet to be brought on line. Thus, we would retain the spousal impoverishment protection, protect the long-term hospitalization benefit, and protect the skilled nursing facility benefit, while delaying the surtax and provisions such as the outpatient prescription drug program. This proposal also protects the Medicaid buy-in and the program for pregnant women and infants.

The distinguished Republican leader just described a proposal that is being discussed to make participation in the Act voluntary, Senator Wallop also has a proposal that would address the voluntary issue. Mr. Chairman, telling seniors that we are going to make the Act voluntary, and in doing so make it so that if they got out of catastrophic that they would be denied the ability to participate in Medicare under Part B. I do not think seniors would agree with such a proposal.

If the committee is going to move in the direction of making the Act voluntary, lets make it truly voluntary. If voluntary ends up being the committee's direction, consider making the Act voluntary by creating a Part C. Create a Part C. This would really put to test the perception of some that this new program is the best thing that we've seen in a long time. The view of some members of this Committee seems to be, once seniors figure out what the program is all about, they will want to participate. If that is so, then let us give them a Part C. Then, they can choose Part C. Make it truly voluntary or involuntary.

Another idea I have read in the media that is being considered by the Chairman of this Committee, and others, is lowering the premiums. I think lowering the premiums would be a wonderful idea, Mr. Chairman. History shows us, however, that every single health care program ever enacted by Congress always exceeded, always exceeded, the original estimates sometimes by four and five times the amount originally estimated.

Also, let me point out, the Congressional Budget Office is already reestimating the costs of the prescription drug program. They are already reestimating it, and they are finding out that the costs of the program are going to far exceed the original projections. So before we take what I think would be a bandaid approach, and that is basically reducing surtax, let us look at what the actual costs will be. I think particularly the prescription drug part of the program may far exceed the original estimates.

Next to finally, Mr. Chairman, most people in this country do not have the opportunity to come to Washington. I hope this Committee will seek the opportunity to go around the country and listen to the American people on this issue. This is a crucial issue with the seniors of Americans. I hope you will give them the opportunity to make their views known.

Finally, Mr. Chairman, there is a fire storm out there. The intensity is increasing; it is not decreasing. These are not greedy Americans. They are American citizens who have now found themselves with a program that they did not want and they do not need. They find portions of this program they do want. The proposal I make preserves those programs that they need—the spousal impoverishment protection, the skilled nursing facility and home catastrophic hospitalization benefits, the Medicaid buy-in, and the program for pregnant mothers and infants. These would be preserved, and I think we should and must preserve those. We can pay for these provisions with the $4 a month increase which has already been levied on Part B.

Mr. Chairman, let us examine piece by piece, part by part, the rest of the program. Rejecting those that the majority of senior citizens clearly having stated that they do not want, and need at this time, and then move forward in a bipartisan fashion and address the issue of long-term care which is indeed the most pressing and compelling need of seniors across this country.

I thank you, Mr. Chairman, for your indulgence, your patience, and the courtesy you have extended to me on this issue as has Senator Packwood and others as we have winded our way through this very difficult and sometime contentious issue.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator McCain.

Are there questions of the Senator?

Senator DOLE. I just have one question.

The CHAIRMAN. Yes.

Senator DOLE. Not a question, really, Senator McCain. But I would first thank you for your leadership. As you know the Administration has a different position because of the loss. Was it $4 billion?

Senator MCCAIN. Three point something, I believe, yes, sir.

Senator DOLE. I do not know how you address that in your statement or whether—maybe we can take care of that by taking a look at these benefits that some have alluded to. Maybe the program is more than we can pay for at this time.

Senator MCCAIN. I think Senator Dole raises a very important point here, at least from the OMB green eye shade viewpoint. It seems to me, however, somewhat violaceous to say that we passed a piece of legislation for which we are going to collect taxes from senior citizens, for benefits to be provided later which the majority of seniors, at least a large number of them, feel they do not need. And now we find ourselves in a budget crunch because we have created a surplus.

I do not believe that it is the intent of legislation to somehow, through smoke and mirrors, disguise the size of the budget deficit. Although, the budgetary aspects of this issue are important because of Gramm-Rudman and all the other things of which we are very well aware. But, to me, it is in no way a rationale for preserving the program as it is.

The CHAIRMAN. Well, Senator, we still have to face up to the fact that we have an enormous deficit and we are trying to meet those budget commitments.

Senator McCAIN. I agree with that.

The CHAIRMAN. So we would have to deal with it in a responsible way.

Senator McCAIN. Thank you, Mr. Chairman.

The CHAIRMAN. If we do find ourselves in a situation where we cut premiums, which has become more of a question whether we can as we hear new numbers coming out of CBO, but I think we have to face the issue. It is well and good to talk about benefits but if you do not pay for them we have a real problem.

Senator CHAFEE. Mr. Chairman, I would like to ask Senator McCain a question, if I might.

Senator, on your proposal to postpone the supplemental and keep the spousal impoverishment and some of the other provisions paid for by the increase in the monthly—the Part B premium, has that been costed out by CBO and OMB?

Senator McCAIN. Yes, it has.

Senator CHAFEE. First, do they agree? I suppose not.

Senator McCAIN. It has been costed by CBO. I do not know about OMB.

Senator CHAFEE. Okay. CBO agrees with what? That it pays for itself?

Senator McCAIN. They agree that the increase in the flat Part B premium would pay for those programs. Yes, Mr. Chairman.

Senator CHAFEE. So essentially what you are dropping is the prescription drug?

Senator McCAIN. And mammogram and several other programs that are included in the Act.

I might also say that I agree with the Chairman and you, the budget deficit is a problem. It must be addressed. But, again, my response is, do we raise people's taxes whether they be social security or any other in order to create an illusion that the deficit is being addressed when we know that over time those taxes that we are raising will be drained sooner or later by the beneficiaries?

I am in no way denigrating the importance of the deficit and the impact on this. But it seems to me we created a trust fund which was to be used to pay benefits, not to reduce the deficit. If those benefits are not needed, then it seems to me that this is a secondary consideration to laying an additional tax on the backs of people who simply tell me they cannot afford it.

But in answer to your question, sir—I'm sorry for that editorial—is that——

Senator CHAFEE. I have no dog in that fight.

Senator McCAIN. CBO says the $4.80 does pay for those three programs—the skilled nursing facility benefit, the catastrophic hospitalization benefit, and preservation of the spousal impoverishment protection.

Senator CHAFEE. Thank you.

Senator McCAIN. Thank you.

The CHAIRMAN. Thank you.

Any other questions?

[No response.]

The **CHAIRMAN**. Thank you very much, Senator.

Senator **McCAIN**. Thank you, Mr. Chairman.

The **CHAIRMAN**. Mr. Fawell, thank you for your patience. We are pleased to have you.

STATEMENT OF HON. HARRIS W. FAWELL, A U.S. REPRESENTATIVE FROM ILLINOIS

Congressman **FAWELL**. Thank you, Mr. Chairman. I do have a prepared statement. I will summarize portions, but otherwise I will not repeat points that have already been made.

The **CHAIRMAN**. Thank you because we have quite a number of witnesses to hear today. Thank you.

Congressman **FAWELL**. First, I want to say thank you very much for once again opening your hearings. In regard to the possibility of funding estimates being altered and the voluntary aspect of this measure, I do appreciate that very much. I would like to read a statement by Joan Beck.

Perhaps if I can be of any help to the Committee at all it might be in regard to relating how the seniors feel. I agree with Senator McCain, these are not selfish people who are not willing to give a lot and, indeed, they have done a great deal for this great nation of ours.

Joan Beck is a syndicated columnist with the Chicago Tribune and she recently said in testifying before our Task Force Committee on this bill that, "Thousands of senior citizens have tried very hard to change the Medicare Catastrophic Care Act—in all of the civics textbooks ways. They have written bags full of letters to members of Congress. They have formed coalitions, lobbied, held meetings. They have had surveys and polls taken. They persuaded sympathetic members of Congress to introduce bills to repeal or postpone or amend the law—and watched the proposals molder in committees, by and large."

Again, you are to be commended, Mr. Chairman, that this Committee is not one that allows things just to molder. You are trying to grapple with it I know and I commend you for that.

I would express my feeling, and I think most seniors share my feeling, that there ought to be a repeal simply because we went in the wrong direction. We could not have done, I think—well, these are awfully strong words that I'm uttering here—but to utilize a special income tax for special people to try to finance this is something seniors are deeply frustrated about.

I think it is in the wrong direction because we have gone to expanding Medicare in the traditional areas of hospital and physician services. We have added prescription drugs and a number of other areas when seniors are deeply concerned about catastrophic care. Most American families are deeply concerned about this. It is mom and dad or grandma or grandpa, a favorite aunt or whoever it may be. All the blessings of living longer, of course, mean we can defer old age but we cannot set it off.

They are not selfish people. We asked them—it seems to me—and this is what they tell me—we ask them not only that they should self-finance but we also told them they are going to subsidize for a relatively large group of other people. Then we did not really sit down and say, what do you want, by the way, in terms of what you are going to have to self-finance?

Seniors recognize that as they look at long-term custodial nursing home care which is what they thought was in this bill that they do know they are going to have to share in the cost. I do not think that the Federal Government has to assume that burden all by itself. But we other words told them they have got to self-finance. We told them they have to subsidize others with a special income tax on these special people and they are middle income people. The very rich can afford it—the very, very rich. The caps even protect them. The very poor have Medicaid.

Seventy percent—more than that probably—75 percent do have medigap or they have employer-provided insurance care which we are pushing in all other policies in this Federal Government that that is what ought to be done. They are coming in and saying, here you are elbowing out the private insurance industry completely and we think that if we are going to be called upon to participate—and because of the deficit problem I think they recognize that some participation of seniors is absolutely essential, they look to the private industry too, they look for the possibility of 2 or 3 years of coinsurance deductibles and things of this sort, so that the private insurance industry would have a chance to be able to participate, et cetera.

Then they say, you not only did all of this but you made it, you know, absolutely—it is not voluntary, the mere fact that I am eligible. I might be 67 years of age working for a corporation. I have employer-provided insurance. Bango! I am hit! Everybody is hit.

Their feeling is that that just was not fair. I tend to agree with them. They are also saying that when you come up with a tax on a tax and have the title, "Supplemental Premium" that that was not fair. That we have breached every promise we made in the Tax Reform Act when we said we took away a number of tax credits and deductions and income exclusions and we said we will not, as far as all of America is concerned, increase income taxes but we did it and for one group--the senior citizens who are proscribed and tied in their ability to be able to earn because of the social security earnings test and for other reasons. They cannot go out and pick up a job as easily as many people can.

These are middle class seniors. It is an open-ended surtax—a tax on a tax which invites a double hit every time we redefine the definition of gross income, every time we alter those rates. We are always flirting with this and we know we are going to be doing it more, they get a double hit, with the increase in rate, the new definition of income and then they get a tax on the rate also.

That is what they continuously bring out to me. That we have gone in the wrong direction and we have utilized one of the worst modes of financing. In regard to changing the estimates in reference to what the cost of this program, which was originally estimated at $31 billion to $35 billion over a 5-year phasein period only, I agree with what Senator McCain has indicated and what the Chairman has just indicated. That that probably is not a very good idea and, indeed, Congress has been notoriously always underestimating the cost of Medicare.

When Medicare first came into being in 1965 we said by 1990 it will cost $8.8 billion. Well we missed by close to $100 billion. We do it all the time and we are certainly not perfect here. HCFA has made it clear that in so far as the prescription drug program, absolutely, there is going to be a shortfall and there is an incentive to buy drugs. As Senator Pryor has pointed out, there is the greatest markup you will ever find and we are going to contribute a great deal to that.

I think that in my opinion that we really ought to repeal it. I do not think that is going to happen. I fully endorse the McCain amendment as the next best approach. It is a consensus of our Task Force over in the House—two of the Republican Task Forces studying this. We believe that, let us freeze what we have, but my goodness, let us hold back, let us review and let us think in terms of how we can after we talk to seniors move toward long-term custodial nursing home care. Which I repeat, I do not expect—nobody expects—the Federal Government to fully fund it. But, there can be a tri-partide cooperation here between the senior citizens who will help to self-finance. That and the Worthland report showed that. You can also have the private industry partake and you can have some Federal governmental responsibilities there too, it seems to me.

Let me conclude with just one final—and this is a harsh statement that Mrs. Beck made—I do not mean to imply this detrimentally to any member, least of all to the Chairman. But she said the letters senior citizens have written to her go along this line, "Their letters call the Medicare Catastrophic Coverage Act a hoax, a sham, a rip-off, a catastrophe itself, a nightmare, a clever ploy to soak retirees and shave the deficit, a sick joke, a swindle, 'elderly bashing,' and in the words of a veteran from Bessemer, Alabama, "a financial Pearl Harbor sneak attack."

Nobody in this Committee had any such intentions. We went so fast on this that we just kind of—it grew like a little topsy it seems and we came up with something that was the Catastrophic Coverage Act and AARP was for it and everybody thought it was a great thing. I voted against it. Maybe I am lucky.

But now we have and we should take the ought time to say, look we made a mistake. We are not perfect. Let us try to see what funds we have available from seniors. What may be available from government, how we can bring the private insurance industry into this and let us see if we can craft a program that everybody really wants—long-term custodial nursing home care. Again, not only seniors but just about every family in America because we all or will be facing this kind of a tussle and crisis in our family.

The CHAIRMAN. Thank you very much.

Congressman FAWELL. I have talked too long. Mr. Chairman, I thank you again for the opportunity of allowing me a seat in this important hearing.

The CHAIRMAN. Mr. Fawell, thank you very much. I must tell you that this Committee labored long and hard on that, had all kinds of hearings, listened to all the interest groups, worked at it at length trying to develop a piece of legislation that met these concerns. I seriously doubt you will ever pass any major piece of legislation that satisfies everyone. There are no questions, but what there are some inequities in this. We are working to try to correct them.

We are going to devote some more attention to it, some more effort to it and that will be our objective. When we get all through not everyone will be happy.

Congressman **Fawell**. Thank you, Mr. Chairman.

The **Chairman**. Are there other comments?

[No response.]

[The prepared statement of Congressman Fawell appears in the appendix.]

The **Chairman**. Mr. Rhodes.

Congressman **Rhodes**. Thank you, Mr. Chairman.

The **Chairman**. The other distinguished son of a distinguished father. Your father is a long time friend of mine.

Congressman **Rhodes**. Thank you, sir.

The **Chairman**. It is nice to have you.

STATEMENT OF HON. JOHN J. RHODES III, A U.S. REPRESENTATIVE FROM ARIZONA

Congressman **Rhodes**. Thank you, Mr. Chairman. I would like to say that Congressman Fawell and I both voted against this and, Harris, I do not believe we were lucky, I think we were very farsighted, maybe also lucky, Mr. Chairman.

I, too, have a prepared statement which in the interest of time I would like to submit for the record. I just have three brief points I would like to make. I think we have heard from the testimony and the opening statements here today so far that delay and study really is not necessary, Mr. Chairman.

I think that we have already identified the problems with this legislation and I think we know enough right now in this session of Congress to go ahead and reform the legislation. I have a vehicle introduced in the House, H.R. 2055, which is along many of the same lines as Senator McCain's in terms of what it retains and in terms of what it would propose to do away with. But it does not delay. It simply says, we have identified the problems that exist here and we have the information available to us to proceed to reform this legislation now.

I am concerned about delay for a lot of reasons, not the least of which is, Mr. Chairman, I think it is just going to keep this issue an item of great concern and of great confusion and of great contention throughout the country for so long as we delay it and delay taking final action on it. So I would commend to your Committee, at least for your review, H.R. 2055, to see if it has some elements in it that could be of interest to you.

Secondly, I would like to address the question of the drugs. I am very pleased to hear your comments and your opening statements because, again, when Congressman Fawell and I began work on this some months ago we became very concerned about some numbers that we saw concerning the drug benefit. We were very concerned that the drug benefit could easily go into deficit immediately upon its implementation—not 2 years, not 3 years, but in the first year—that there is so much uncertainty about the drug benefit, there is so much concern about some of the issues that Senator

Pryor mentioned. That this benefit alone could have a devastating impact on the entire Medicare trust fund and that we simply do not, first of all, know enough about it; and secondly, we made it far too broad in its coverage.

In my legislation we take the drug benefit out of Medicare altogether, institute a benefit in Medicaid for those individuals, first of all, who are over 65 and secondly, whose income is at 150 percent of the Federal poverty level with a $50 deductible. It puts the drug benefit in the program and for the benefit of the people who genuinely need that benefit in a way that we can afford it.

Lastly, I would like to take a moment to address the question that we all have to face concerning the impact of reforming this legislation on the budget. It concerns me. It concerns all of us. There is not a member of either the House or the Senate, Democrat or Republican, who is not deeply concerned about the deficit situation.

But it concerns me as well for us to say to a specified group of people, as at least I am willing to say, we passed an ill-advised, ill-conceived piece of legislation—partially ill-advised and partially ill-conceived. We financed some portions of it by a tax that is levied on a limited portion of the population. We now recognize that the benefits which are to be directly financed by that tax are either not needed or we cannot afford them or are available in other forms and we would like to recognize your concerns about those benefits and the costs of them and do away with them.

But we cannot do it because we need your $3.7 billion in revenue. We have already counted that $3.7 billion. We put it into the revenue side of our ledger and so you are stuck. You are now a $3.7 billion portion of the budget deficit solution.

Senator, I do not think any of us either want to or would like to try to sell that proposition to the over 65 population of this country. I do not think that is fair. I do not think that is what we intended to do. I do not think that is was ever the intention of any member of the Congress to use the over 65 population as a $3.7 billion contribution to reduction of the deficit. We intended to use that money to provide some benefits that we now question whether we should be doing.

I doubt seriously that anybody in the Congress is as dedicated to reduction of the deficit as you and I are, but I just do not think that is a fair proposition to the people that are affected by this legislation.

I also thank you, Senator, for taking the courageous step of reopening this issue. It will be difficult. You are to be commended and I appreciate the opportunity to appear before the Committee this morning.

The CHAIRMAN. Thank you very much, Mr. Rhodes.

I have stated early on that if you have a surplus in this there is no sense in trying to finance the budget with it, if you have that surplus. But the problem is, I am having trouble finding numbers I can count on. I had them testifying here before us June 1 that we are going to have an enormous surplus. I met with them last night and now they are changing their numbers.

I heard an earlier comment that Congress has a history of underestimating these things. Congress depends on so-called experts. So you have the OMB that gives you numbers and CBO gives you numbers. Finally, you try to decide which one is right. Congress then follows that. But we have had some major misses on it. I agree to that.

Senator Packwood.

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. No questions, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Rhodes.

Congressman RHODES. Thank you, Mr. Chairman.

[The prepared statement of Congressman Rhodes appears in the appendix.]

The CHAIRMAN. Now we have a panel of Mr. David Newhall, the Acting Assistant Secretary of Defense [Health Affairs), and Mr. Frank Titus, the Acting Associate Director for Retirement and Insurance Group of the Office of Personnel Management. Gentlemen, we are pleased to have you.

Mr. Newhall, if you would lead off.

STATEMENT OF DAVID NEWHALL, III, ACTING ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS), DEPARTMENT OF DEFENSE

Mr. NEWHALL. Thank you, Mr. Chairman, Senator Packwood, Senator Baucus.

The CHAIRMAN. I would ask all of you to please hold your statements to 5 minutes so we can ask the questions and we will take your entire statement in the record.

Mr. NEWHALL. Certainly, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. NEWHALL. I appreciate your invitation to testify today. You have asked that I address——

The CHAIRMAN. Now there are a lot of people here who want to hear what you have to say. So why don't you move that mike up like you are about to eat it.

Mr. NEWHALL. All right. Is that better, Mr. Chairman?

I appreciate the opportunity to be here and to address the implications of the Catastrophic Act on the military health benefit system. Our system is dedicated to ensuring that we are capable of providing life saving care to our fighting forces in time of war. In peace time we are responsible for providing cost-effective, quality medical care to over 9 million beneficiaries. These beneficiaries include the uniformed force, retired members of the Armed Forces, and their dependents.

We operate over 500 medical facilities, including 130 hospitals in the continental United States. We refer to this network of our own military medical facilities as the direct care system. In addition to our own military hospitals and clinics, we also oversee operation of the Civilian Health and Medical Program of the Uniformed Services, known as CHAMPUS. The CHAMPUS program, on a cost-share basis, reimburses for authorized health care obtained from civilian providers by our beneficiaries, when care is not available in one of our hospitals or clinics.

It is important to note, Mr. Chairman, that, by statute, Medicare beneficiaries are not eligible for CHAMPUS coverage. When a military beneficiary is eligible for Medicare coverage, CHAMPUS eligibility ceases. Eligibility for care in our military hospitals and clinics, however, continues with Medicare eligibility, but eligibility does not mean that the care will be available in our military hospitals and clinics.

Care is available on a space-available basis. That is, subject to the availability of space and facilities and physicians and other providers. The commanding officer of each facility determines availability. Emergency care will, of course, be provided at all times to all beneficiaries. However, when the commanding officer determines that there is not sufficient space, physicians or other treaters, care is provided in priority order.

Priority 1: To uniform personnel.

Priority 2: To the dependents of active duty personnel and dependents of members who died in the service of their country.

Priority 3: To retired members and their dependents.

Of our 9 plus million beneficiary population, slightly more than 720,000 or 8 percent are Medicare eligible. This means that of the total 33 million persons affected by the Medicare Catastrophic Coverage Act, slightly more than 2 percent are also eligible to receive care in military hospitals and clinics but are not assured of receiving it.

Charges to our beneficiaries at military hospitals and clinics are virtually nonexistence. In-patient care is provided at a rate of $8.05 per day for dependents and a small subsistence charge for military personnel. There is no charge for outpatient care or for prescription drugs. Consequently, military treatment facilities are understandably a popular source of care for eligible retirees and their dependents. Because care at military facilities is essentially free, this popularity will not be affected by the Medicare Catastrophic Coverage Act. The constraining factor in military treatment facilities for the care sought by Medicare-eligibles is space or the availability of treatment staff.

Thus, beneficiaries dually entitled to DOD and Medicare benefits, may receive care in a military facility if that care is available. This varies substantially from one military hospital to another and even from day to day.

Given these parameters, how much care are we at the Department of Defense providing to this dually eligible population? Of the total 923,000 admissions handled by the direct care system in fiscal year 1987, 67,000 or 7 percent were admissions of beneficiaries over age 65. Based on a 1984 survey of our beneficiaries, we feel that somewhat under half, probably around 45 percent of total in-patient care provided to the dually eligible population is provided in our military hospitals. In other words, somewhat over half of the care provided to Medicare-eligibles who are also eligible for care in DOD facilities is received outside of our hospitals and probably covered by Medicare.

In conclusion, we have no plans to reduce the level or amount of care available for the over 65 beneficiary in military medical facilities. We are trying at least to maintain—and, Mr. Chairman, it has been a struggle—our current level of care. I must emphasize that we could never come close to handling the total medical care requirements of this population.

Thank you, Mr. Chairman. I'll be glad to answer any questions.

[The prepared statement of Mr. Newhall appears in the appendix.]

The CHAIRMAN. Well, let us have both of you testify first. So, Mr. Titus, if you would proceed.

STATEMENT OF FRANK D. TITUS, ACTING ASSOCIATE DIRECTOR, RETIREMENT AND INSURANCE GROUP, OFFICE OF PERSONNEL MANAGEMENT, ACCOMPANIED BY NANCY KICHAK, DIRECTOR, OFFICE OF ACTUARIES

Mr. TITUS. Thank you. Mr. Chairman, and members of the Committee. I would first like to introduce Nancy Kichak, who is accompanying me this morning. She is the Director of our Office of the Actuaries.

The CHAIRMAN. All right.

Mr. TITUS. Thank you for inviting me to join you today. I appreciate the opportunity this hearing will afford to survey the impact of the Medicare Catastrophic Coverage Act of 1988 on individuals subject to employee-sponsored health insurance plans such as the Federal employees health benefits plan and to evaluate the effectiveness of the provision in that law requiring maintenance of effort on the part of the employer plan. That is, substitution of additional benefits for coverages newly assumed by Medicare, refunds to Medicare eligibles of the actuarial value of the duplicate coverage or some combination of these approaches.

Section 442 of the Catastrophic Act requires OPM, in consultation with insurers offering health benefits plans under the FEHB program, to establish an FEHB premium reduction with respect to enrollees who are also entitled to primary coverage under both Parts A and B of Medicare. The reduction is required to be a uniform amount equal to the estimated cost of medical services and supplies which would have been covered by FEHB plans had Medicare catastrophic benefits not been enacted. The estimate is prorated by the number of Medicare eligible FEHB enrollees.

After engaging an independent consultant to assess our computation of the rebate amount together with insurance carrier comments on its appropriateness, OPM announced in a Federal Register notice dated October 26, 1988 that the 1989 FEHB rate reduction for Medicare eligible annuitants would amount to $3.10 per month. A General Accounting Office report, dated March 23, 1989, concluded that OPM's rebate determination is consistent with the health care financing administration's projection of the 1989 national average cost of catastrophic coverage changes and appears to be reasonable.

As the situation now stands, OPM must continue to make rebate determinations under the Catastrophic Coverage Act indefinitely because the FEHB law does not currently authorize OPM to contract for plans expressly designed to supplement Medicare's coverage. Medicare coverage was not even uniformly available to Federal employees until 1983.

Most private employers, however, have long adjusted their post-retirement health care plans to explicitly compliment Medicare benefits. Even if such employers pay all or a high percentage of health insurance premiums, they find the so-called medigap plans advantageous because they are generally cheaper and more comprehensive than employee plans and retirees benefit from coverage more appropriate to their needs.

Section 423 of the Catastrophic Act required OPM to conduct two studies related to the possible offering of Medicare supplemental plans under the FEHB program and to submit them to appropriate congressional committees. One study was to identify FEHB program changes which would be necessary in order to incorporate plans expressly designed to supplement Medicare and to improve the efficiency and effectiveness of this program.

The second study called for by Section 423 concerned the feasibility of adopting standards by the National Association of Insurance Commissions for Medicare supplemental plans in the event such plans are offered to Federal annuitants.

OPM prepared a consolidated report on these issues which is dated April 1989. Under the Act, the NAIC was given 90 days to issue new minimum standards for Medicare supplemental policies. After reviewing these standards, OPM concluded that they were reasonable and that any product sponsored or made available under the Federal program for its annuitants should be consistent with them.

Unfortunately, the other issue identified for the study cannot be dealt with so quickly. Prior to enactment of the Catastrophic Act, OPM contracted with a benefits consultant for a comprehensive study of our program. In its final April 1988 report, the consultant identified serious problems of risk selection and economic inefficiency. As part of an overall reform, the consultant specifically recommended that Medicare eligible annuitants be removed from the general risk pool and placed in special Medicare supplemental plans.

There are equity issues resulting from the fact that increasingly Medicare eligible annuitants who have been paying taxes for Medicare coverage, are still paying FEHB premiums, as if Medicare did not exist. However, the primary argument against immediate action to establish special plans in the FEHB program, independent of major structural reform is that simply removing these Medicare eligibles from the general risk pool is certain to increase the premiums for the remaining FEHB enrollees, and more importantly, result in a major destabilization of an already precarious program.

The destabilization would occur, moreover, at a time of great physical constraint when budgetary limitations demand a predictable and controllable levels of government expenditures and minimal enrollee increases.

Thank you very much. I would be happy to answer any questions.

The **Chairman**. All right. Thank you.

Mr. Newhall, I was trying to follow all those numbers of yours. So let me just cut through all of them and ask you, can you advise this Committee as to whether or not military retirees have been treated equitably under the catastrophic illness bill and if not, what you think we ought to do about it.

Mr. NEWHALL. Mr. Chairman, I am not sure I am qualified to respond. I am not sure I know enough about all the ins and outs of the Act. But I can say this, having heard the testimony this morning, that any suggestion that the vast majority of care is provided to military retirees in our facility would be an incorrect suggestion. We provide a very large amount of care, but I do not think it is quite half of the total care received by the Medicare eligible population.

The CHAIRMAN. Well, as I recall some of the numbers you were talking about, it was about 45 percent.

Mr. NEWHALL. Yes, sir.

The CHAIRMAN. You were talking about them based on availability and all that. You finally got down to about 2 percent of the people, as I remember. Isn't that one of the numbers you gave me?

Mr. NEWHALL. That is correct, Mr. Chairman.

I do not see any significant expansion in the amount of care that we will be able to provide to any of our other than uniformed beneficiaries. I noted in my statement we do not foresee a cutback, but we are having hard times with access, with long lines. We are having real problems providing a level of care that we provided in earlier years. So I do not see any significant expansion.

The CHAIRMAN. We are getting complaints, you know, from military retirees and we are trying to figure out how to best address them to be sure they get equity in whatever we have in the way of catastrophic illness. You have no specific recommendations in regard to that?

Mr. NEWHALL. No, sir. I did not come prepared with recommendations.

The CHAIRMAN. If you come up with some, we would be delighted to hear them.

Mr. NEWHALL. Thank you, Mr. Chairman.

The CHAIRMAN. Now let me ask you the same question, Mr. Titus. Do you think that when we get to Federal retirees that they are being treated equitably under the catastrophic illness legislation and if not, what do you think needs to be changed?

Mr. TITUS. I am not sure if you are asking whether they are being treated equitably by the legislation or if my opinion is how that legislation is interacting with the FEHB program.

The CHAIRMAN. It is the same deal.

Mr. TITUS. All right. In terms of——

The CHAIRMAN. I am not giving you any out. I still want an answer.

Mr. TITUS. All right, sir. In terms of how the catastrophic legislation has affected the FEHB program, I would say, as I testified, that there are equity issues. That a number of studies have shown that the Medicare-eligible population has probably purchased more insurance than it actually needs under the FEHB program. And that in terms of the overall program that the Medicare covered annuitants—and I am referring to those covered by both Medicare A and B—have somewhat of a subsidizing effect on the overall program.

One of the reasons why these individuals may be purchasing more insurance than arguably need is that it is difficult to perceive exactly how the Medicare coverage coordinates with the FEHB program. If we had a medigap program, it would be much simpler, simpler for our enrollees to understand and perhaps less expensive.

The CHAIRMAN. Some of the things you are suggesting would be, I assume, coming under the Governmental Affairs Committee and I have written the Chairman, Senator Glenn, concerning what plans he might have so that we could try to see that we mesh them so they are more complimentary to each other.

I have no further questions.

Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

Mr. Newhall, about the study that you are citing when you say that about half of the needs of your 720,000 eligibles were met by military hospitals. In total needs, I suppose you are including drugs and in-patient care. That survey was 1984, if I understand it from your testimony, which was 5 years ago.

Just as an observer, first, I am astonished that you only have 720,000 over 65 you are dealing with. In other words, you would think amongst all your military retirees you would have more than that that are over 65. I suspect the numbers have grown and are continually growing as the population lives longer. So that must be an ever growing number, is it not?

Mr. NEWHALL. That is very correct, Senator. For example, between 1985 and 1987 our over 65 population, the Medicare eligible, grew by 13 percent. Care rendered, using that same base year of 1985, grew by only 7.5 percent on the inpatient side. So it is, indeed, a very fast growing portion of the population.

But the rate of care being rendered has fallen off some from peak years. I expect that you will not see any sharp increase in the amount of care being rendered inside.

Senator CHAFEE. Well, I think that probably your ability—you, being the Defense Department—your ability to service these individuals in your military hospitals is as you say not merely going to hold its own at 50 percent, it is going to decline.

Mr. NEWHALL. It has already started to decline, Senator.

Senator CHAFEE. Even if you have a hospital where services are available, frequently the services are not of the type that the seniors might need. In other words, because of your selection of doctors and the specialties that the doctors practice in every hospital is not available.

Mr. NEWHALL. In some cases, though, I would note, Senator, as you know from your time as Secretary of the Navy, our hospitals have very extensive graduate medical education. We train an awful lot of residents each year and thus we need the retiree pathology, if you will, to conduct our training programs and to keep our physicians well trained and prepared for their wartime tasks.

Senator CHAFEE. In summary, the situation is going to get more challenging for your seniors, that is your over 65 population.

Mr. NEWHALL. I think that is fair observation, sir.

Senator CHAFEE. Now, Mr. Titus, a question for you. The retirees that use your programs have an option, do they not, in other words there is not something built into the program that they are carrying over due to the fact that they are retirees. They have to pay for it. They make a selection for, and it is a very vast group that they can—a number of programs that they can select from, is that not true?

Mr. TITUS. Yes, that is true. The program is funded on a year-by-year basis so you are not prepaying in any way for your retirement.

Senator CHAFEE. In other words, if a retiree chose not to take any of the programs and pay for them, that retiree would not be eligible for any type of medical care as a retiree; is that not correct?

Mr. TITUS. That is correct unless it was attained privately.

Senator CHAFEE. That is right. But I am talking from the Federal Government. In other words, you do not—it is not like a United Auto Worker who retires from his job and is covered for life under certain programs. A Federal retiree is only covered if he or she pays for it; is that correct?

Mr. TITUS. That is correct. They pay on the same basis and the same premiums as you and I with the exception of the rebate that we make for the Medicare eligibles.

Senator CHAFEE. So that if a retiree understood this program and realized what benefits there were under it—I am talking about catastrophic—the retiree then could drop those Federal retiree health programs that he or she was paying for and save some money.

Mr. TITUS. The retiree would be better advised to pick one of the plans with a lower level of benefits that best compliments the Medicare program. If the retiree dropped our insurance entirely there might not be coverage for a spouse or a dependent child and there would not be coverage for some of the co-insurance and deductibles.

Senator CHAFEE. One last question, if I might, Mr. Chairman.

The CHAIRMAN. Sure.

Senator CHAFEE. To say that Federal retirees are automatically involved in a duplicative situation is not quite accurate because if this program remained in effect—the catastrophic program, that is—the Federal employee could drop those programs, not pay for them, or select one that would fill in whatever gaps are still exposed under the catastrophic. But he or she would not automatically have a duplicative situation.

Mr. TITUS. That is true. They could continue our coverage until the point in time they became eligible for Medicare and then drop it. If they did so, they would not—if they changed their mind—be able to pick it up again, however.

Senator CHAFEE. Well, that is a separate situation. You mean if you drop out of a Federal program you cannot go back in?

Mr. TITUS. As a retiree, yes.

The CHAIRMAN. Thank you.

Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Titus, following up on that, why can't that restriction be changed? That is, why can't some measure be taken so that if some employee opts out that at some later date, that employee could opt back in again?

Mr. TITUS. It could be changed. I believe it would require legislation.

Senator BAUCUS. It seems to me that we want to fashion the program in a way that treats Federal employees and retirees fairly. Either Federal retirement programs should be changed so that they are not duplicative or an option should be available to Federal retirees, so that they are not paying twice and do not have duplicative coverage. Can't that be set up some way?

Mr. TITUS. Well, yes it can. That is our objective, too. Notwithstanding the Medicare Catastrophic Act we believe very strongly that the FEHB program needs to be reformed. That need existed before Medicare catastrophic; it will exist even should Medicare catastrophic be delayed. Certainly, that reform needs to specifically address the Medicare provisions, including the catastrophic provisions.

Senator BAUCUS. Would you oppose any congressional provision that would allow the Federal plans to be changed so that an employee, after a reasonable period, could opt back in?

Mr. TITUS. I am not prepared to respond to that at this time.

Senator BAUCUS. Is that not somewhat integral to the issues we are facing today?

Mr. TITUS. I think that if we had a reformed program with a medigap plan specifically tailored to the Medicare program, including the catastrophic provisions, that there then would be no incentive for a person to drop out. However, if we had such an arrangement I am quite sure that we would favorably consider evaluating allowing people to drop out and reenter as a feature of a reformed program.

Senator BAUCUS. Assuming we can figure out some way to take care of the duplicative problem, does your organization have a view of whether we should drop some of the benefits in order to reduce some of the premiums or supplemental income tax?

Mr. TITUS. I am not aware of any view on those subjects.

Senator BAUCUS. Sorry?

Mr. TITUS. I am not aware of any view on those subjects.

Senator BAUCUS. What would your personal view be?

Mr. TITUS. My response would have to be that I really have not evaluated them and so I could not make an informed judgment on that.

Senator BAUCUS. Do you think it makes sense for us to work a tightly sculpted catastrophic coverage program that is in fact catastrophic and deal with long-term health care issues at a later date?

Mr. TITUS. Well, I can tell you that last year the previous Director of the Office of Personnel Management and the Reagan Administration advanced long-term care legislation under our insurance program—our life insurance program—as a means of addressing that issue with respect to Federal employees.

Senator BAUCUS. I have no further questions. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Packwood.

Senator PACKWOOD. No questions, Mr. Chairman.

The CHAIRMAN. Senator Bradley.

Senator BRADLEY. Thank you very much, Mr. Chairman.

Mr. Titus, I just want to ask you if you think the $3.10 premium reduction adequately compensates Federal retirees for duplication of coverage.

Mr. TITUS. Yes, that is my opinion. Again, it was evaluated by the General Accounting Office who agreed that the estimate was reasonable.

Senator BRADLEY. What are the areas that are most frequently duplicated?

Mr. TITUS. I will ask Nancy to speak to the elements of the calculation.

Ms. KICHAK. Okay. For 1989 the duplicative benefits were the multiple deductible for hospital admissions, the co-insurance for over 60 days and the payment for care in excess of the life time reserve. Most of our health plans were already covering 365 days of hospital care.

Senator BRADLEY. What is your estimate for next year?

Ms. KICHAK. We are required by the legislation to consult with our carriers and we just got in the data on that. Our estimate is not final, but it is ranging between $7 and $9 a month.

Senator BRADLEY. Thank you very much.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Mr. Titus, I am just trying to re-ask this question again, maybe for the third or fourth time. Is it your testimony then that the protection for double coverage under the Medicare Catastrophic Act did, in fact, not do violence or disservice to the Federal retirees that you speak of?

Mr. TITUS. The increased coverage under the Medicare Catastrophic Act is being addressed by the rebate that we are making. The problems with respect to the Federal Employees Health Benefit program I think relate a little bit less to the Catastrophic Act than the fact that the program does not coordinate well with Medicare as a whole.

Senator ROCKEFELLER. So that the problem then, in effect, lies not so much in the Medicare Catastrophic Act itself but in structural problems within FEHB.

Mr. TITUS. There are structural problems. I think that the Medicare Catastrophic Act made people more aware of the relationship between the Medicare program and FEHB because of some of the new premium features. But basically, the problem was there before and it was not created by the Catastrophic Act.

Senator ROCKEFELLER. If the Medicare Catastrophic Act, in whatever form—let us say in present form—were made voluntary, linked to Part B, in your judgment, what percentage of Federal retirees would opt out of the Medicare Catastrophic Act?

Mr. TITUS. I really do not know. I do not have any basis for making an estimate.

Senator ROCKEFELLER. Would there be a significant number, for example?

Ms. KICHAK. We think it would be a significant number that would opt out. The problem is that our annuitants do not often make logical decisions and tend to overinsure. But we would expect a large number to opt out.

Senator ROCKEFELLER. Your testimony then would be that it would be based upon their lack of knowledge of what it is that they have in fact in the way of coverage or that they would opt out perhaps because of structural problems within FEHB, but there is not necessarily a reason for them to opt out because of the nature of the catastrophic Medicare bill?

Ms. KICHAK. I am not sure I understand the question. Let me say that the benefits that the Medicare Catastrophic Act are providing were largely provided previously through the FEHB and, therefore, they can obtain those benefits through our system already.

So when I said we expect a large portion to opt out, if it were voluntary, we would expect them to drop the Part B.

Senator ROCKEFELLER. But Mr. Titus also indicated that there was no inherent difficulty, I thought, in the double coverage protection aspect of the Medicare Catastrophic Act as it now exists. Am I wrong in that, Mr. Titus?

Mr. TITUS. You mean in terms of whether the $3.10 is the appropriate amount to be rebated. No, that is the correct amount. A lot would depend on exactly how the benefits would be coordinated, if they opted out. The benefits that were provided by Medicare Catastrophic, by in large, existed in the program before. So it did not add really new benefits.

If when you say, if they drop out, if the FEHB program then became the primary payor for benefits that were customarily paid by Medicare before the Catastrophic Act then there would be potentially a very significant impact on the FEHB premiums paid by the remaining enrollees as well as the government.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Thank you.

Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

Mr. Titus, following up on Senator Rockefeller, I understand the situation you have with Aetna precludes, in your mind, much of any action right now. But in principle, I gather there would be nothing wrong with FEHB developing a supplemental plan carefully tailored to fit with the catastrophic program, is that right?

Mr. TITUS. I would go beyond saying there is nothing wrong with that. I think that is the correct thing to do.

Senator HEINZ. You would like to do that if you could, would circumstances permit?

Mr. TITUS. Yes. We believe very strongly though that that has to occur within the context of overall restructuring of the program. That you would do great damage to the program if that is all you did.

Senator HEINZ. Dave Newhall, would that be DOD's position as well?

Mr. NEWHALL. It is not something to which I have given a great deal of thought. There is one thing I would point out for the Committee. It is important to recognize that Medicare is an entitlement program and the care that I have talked about earlier with the Chairman and Senator Chafee is an eligibility program. So that as this Committee tries to weigh issues of fairness and so on, on the one hand, you have your entitlement program and you are being asked to consider whether or not an eligibility program will measure up and will offer care because that is all we have is an eligibility program.

Senator HEINZ. If the catastrophic program and Part B, together, were made voluntary, Part B would no longer be as it is now in effect a mandatory entitlement program for which people paying the surpremium can pay rather heavily. If it was voluntary, how would that change the response you just gave?

Mr. NEWHALL. I do not know how to predict behavior, Senator, as far as risk selection. So I do not know that my response is well founded on any facts.

Senator HEINZ. Let me go back to Mr. Titus and say, if you were in a position to do what you want, which is to make some carefully constructed supplemental programs for Federal employees to fit with catastrophic and we made catastrophic as many of us have proposed voluntary as part of Part B, including the payment of the surpremium, what would be the effect, do you think, on Federal employees wanting to participate in the catastrophic program?

Mr. TITUS. I think that that again goes back to exactly how the benefits are coordinated between the FEHB program and this revised Medicare catastrophic program. If the FEHB program would assume liability for benefits for which Medicare was previously the customary first payor, there would be a very significant effect, which is to say an increase, on the overall premium levels of FEHB.

I cannot tell you what that would be. But the retirees' decision in terms of making a rational decision would be comparing those costs and benefits relative to the costs and benefits that would be provided by paying the additional Medicare premiums and purchasing probably a less expensive FEHB plan designed specifically to compliment that Medicare coverage.

So I think that the answer to that has everything to do with exactly how those benefits are coordinated which will spill over into the FEHB premium.

Senator HEINZ. Very well. Thank you very much.

Senator BRADLEY. Senator Roth.

Senator ROTH. Thank you very much, Mr. Chairman.

If you developed a complimentary medigap policy, what kind of benefits would you include in that, Mr. Titus?

Mr. TITUS. We would basically follow the NAIC guidelines in terms of the basic benefit package with the possibility of some additional optional packages that might be purchased at the enrollees' election should the enrollee wish expanded coverage over the NAIC minimum.

Senator ROTH. Federal retiree health premiums have increased approximately 25 percent annually during the last 2 years. What cost containment ideas, if any, are you considering in an effort to restrain price increases in the program? Have you, for example, looked at the cost containment ideas in Medicare or other government health programs?

Mr. TITUS. Cost containment was an area that was addressed by our consultant study that was completed in April of last year. Our most recent action with respect to cost containment has been to poll all of our experienced rated carriers and ask them to give us information about the cost containment strategies that they are employing and specific information about the costs and benefits of those strategies, not only with respect to the FEHB program but also, I believe, with their other lines of business.

We hope then to develop a data base, such that we can make informed decisions about employing cost containment features which have been demonstrated to be cost effective in actual use by the insurance carriers. We have just received that data this summer. We will be looking at it with an eye toward 1991.

Senator ROTH. If OPM were to develop a Medicare supplemental insurance program, could long-term care be incorporated? Are you familiar with the proposal introduced by Senator Pete Wilson, that a number of us have co-sponsored, where you would roll over life insurance policies toward long-term care coverage?

Ms. KICHAK. We are very familiar with that proposal and it was supported by our Agency in the last Administration. We feel that long-term care has to be handled in that way because it is the kind of care that lends itself to long-term pre-funding, rather than acute care which is funded annually as in our FEHB. We have done some pricing of what it would cost to include long-term care in the FEHB and the costs would be exorbitant.

Senator ROTH. That's all the questions I have at this time.

Senator BRADLEY. Mr. Chairman, could I ask one.

The CHAIRMAN. Yes, of course.

Senator BRADLEY. There was a point after I asked my question. I would just like to get clarification. I asked how much is the reduction in premium on behalf of the Federal employee because of duplication between catastrophic and the Federal program and you said about $40 a year this year and next year it could be as much as $108 a year. About $9 you said was the upper limit. Now that is because there is that much duplication.

You made a point in response to Senator Heinz, I think, where you said that if Federal employees opted out of the program that the premium that remaining Federal employees paid would go up. Was that the point or that the premium paid by the remaining recipients of catastrophic care would go up?

Ms. KICHAK. No, the point is that the premium paid by the other employees and annuitants in the program would go up because our Medicare annuitants that are in the same risk pool as our employees and non-Medicare annuitants are a better risk group because of the Medicare coordination. They are cheaper. If they pulled them from Part B, we would spread the claims now paid by Part B over the employees, Medicare annuitants, and non-Medicare annuitants resulting in increased premiums for all enrollees.

Senator BRADLEY. How much more would that be, would you guess?

Ms. KICHAK. In aggregate it is 7 percent. The problem we have with our 400 plans is, in some plans it would—because of the nature and the people in each individual plan—it could affect some plans by as much as 10 to 20 percent and some plans almost not at all.

Senator BRADLEY. In dollars, what is that?

Ms. KICHAK. I cannot do that at the table.

Senator BRADLEY. Okay.

The CHAIRMAN. All right.

Senator BRADLEY. Could you do that and give it as a part of the record?

Ms. KICHAK. Certainly, we will be glad to do that.

The CHAIRMAN. All right.

[The follow information was subsequently received for the record.]

The increase in total benefits that would be payable under the FEHBP if all current annuitants and their spouses who now have both Parts A and B of Medicare dropped Part B is estimated to be $900 million in 1990.

The CHAIRMAN. Thank you. Thank you very much.

Mr. NEWHALL. Thank you, Mr. Chairman.

The CHAIRMAN. Our next panel is Mr. Earl Pomeroy, the vice president of the National Association of Insurance Commissioners of Bismarck, ND; Ms. Gail Shearer, the manager of policy analysis for Consumers Union, Washington, DC.

Mr. Pomeroy, if you would proceed, please. We have a 5 minute rule.

STATEMENT OF EARL R. POMEROY, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AND COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, BISMARCK, ND

Mr. POMEROY. Thank you, Mr. Chairman. I will be abbreviating my written statement which has been submitted. I am Earl Pomeroy, Insurance Commissioner of North Dakota, and Vice Chairman of the NAIC.

The National Association of Insurance of Insurance Commissioners is an organization of the 50 States and four territories and the District of Columbia. Our purpose is to coordinate the insurance regulation between the States throughout the country. We very much appreciate the opportunity to participate in the hearing this morning.

We have seen in the wake of the passage and initial implementation of the catastrophic care extensions to Medicare that attention has been focused on the medigap or Medicare supplement market.

Generally, the questions have fallen into three areas: Have the minimum standards for medigap policies imposed under the so-called Baucus Amendments been adapted to address the changes which have been made in the Medicare program? Secondly, why have premiums charged for the private medigap coverage often failed to decrease in light of the expanded coverages of Medicare? And thirdly, reports of abusive agent and company conduct continue to be received. Are insurance regulators addressing these concerns or is additional Federal action necessary?

I will address each of these briefly in turn. This Committee recognized that the time the initial catastrophic care extensions were contemplated that changes would be required under Baucus. In my preceding testimony to this Committee, while that act was being considered, I was able to extend a commitment that the National Association of Insurance Commissioners within 90 days after implementation of the new law would have new standards developed. We met this commitment and the States are now well down the road toward adopting the NAIC model revisions.

We envisioned that virtually every State will have them in place by September 20, 1989, within 1 year of their initial adoption in model form by the NAIC.

The issue of premium decreases, Mr. Chairman, is one that unfortunately I have to report is the exception rather than the rule by what we have seen in the private market. Initially, regulators reviewed very skeptically the rate filings made with the new products, but we did find actuarial justification for not declining the rates based in some of the following areas—primarily increased providers costs and increased consumer utilization wiped out whatever savings might have been realized by the expanded coverages of the catastrophic care extensions.

In addition, a number of insurers had had a length of time between when they had last filed for rate increases. We have been in a cycle where health care costs have been rising dramatically. Depending on how current their rates, they may have not accommodated increases. Lost ratio performances in prior years also may have justified additional rate increases.

We have found that the 1989 implementation does not bring the full catastrophic care extensions into play and as a result the extensions offered did not offset a great deal of the costs previously covered by the private market.

An invisible benefit to a number of consumers, Mr. Chairman, but a very real one to virtually everyone insured with a private medigap policy, is that their rates would have gone up and would have gone up beyond what they realized but for the extensions of the catastrophic care amendment.

Concerns have been raised by the public——

The CHAIRMAN. What you are saying is they would have gone up more?

Mr. POMEROY. They would have gone up more, Mr. Chairman. The largest insurer of the medigap market in North Dakota, for example, would have realized a 23 percent increase in premium; as it was, it was 2 percent. No decrease, but certainly not the substantial hit it would have been.

Concerns have been raised by the public, as well as members of Congress about several market conduct issues. These include our loss ratios meeting the required levels; are coverages continuing to be duplicated involving needless premiums from consumers; are consumers needlessly being rolled from one coverage to another; are consumer education activities adequate; would standardized policies enhance consumer choices; and finally, are criminal statutes being used—criminal penalties being imposed.

On loss ratios, Mr. Chairman, I can tell you that the NAIC has worked to enforce mandated loss ratios. We have improved our reporting form and I expect that we will be able to monitor, better than we have in recent years, effective 1989 and moving forward, the actual loss ratios.

We have proposed several sweeping consumer protection amendments presently being contemplated to address market conduct abuses. I believe the most important is leveling the commissions charged by the agent between the first year's sale and the renewal commissions. There is presently a stark differential which gives the agent a strong incentive to either duplicate the coverage or roll the insured 1 year to another into a new policy so the agent is always realizing the new commission. I think leveling commission will help.

Finally, in conclusion, Mr. Chairman, I believe that administrative remedies only go so far. This Committee could take the lead in expanding criminal penalties for agent abuse of the public in the sales area. We have recommendations in this area and would welcome the assistance of U.S. Attorneys in our own market enforcement efforts.

[The prepared statement of Mr. Pomeroy appears in the appendix.]

The CHAIRMAN. Thank you.

Ms. Shearer.

STATEMENT OF GAIL E. SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. SHEARER. Thank you, Mr. Chairman, and members of the Committee. Consumers Union appreciates the opportunity to present our views on the catastrophic health care bill and on the issue of private health insurance to supplement Medicare or medigap insurance.

Before addressing the medigap issue, I would like to touch on some of the other issues you are considering today. First, Consumers Union continues to strongly support the catastrophic health care legislation. The benefits it provides senior citizens are substantial. Consumers Union agrees with the principle that the cost should be borne by the elderly because the next Federal health care dollar should be used to help the millions of people under age 65 who lack health insurance.

Long-term care for people of all ages is also an important priority for Consumers Union. But the need for a comprehensive long-term care program should not be used as an excuse to gut this very significant improvement in Medicare benefits. Consumers Union opposes efforts to make catastrophic protection voluntary, either on its own or with Medicare Part B coverage. Making coverage voluntary would seriously jeopardize the financial viability of the Medicare system.

It would allow the private medigap industry to select the healthy and wealthy risks, turning Medicare into a program that specializes in higher health risks and lower income senior citizens. In addition, expanding the role for the private sector would make the challenge of improving the poor performance of this market even greater.

The centerpiece of our recommendation is standardization which holds the potential to dramatically improve the performance of the medigap market. Under standardization policy benefits could not vary from standard levels set forth in low, medium and high policies which would range from less comprehensive to more comprehensive. The government would establish uniform definitions for key policy terms and would restrict the variations allowed for other insurance policy provisions.

Standardization of the medigap market can be achieved without spending a lot of money. While it could yield substantial consumer benefits, it would not require the painful task of coming up with billions of dollars to finance new government benefits.

The key marketing abuses in the Medicare supplement insurance market are first, consumer confusion. Consumers are confused about what Medicare and their private medigap policies cover. The variation in policies makes it virtually impossible for consumers to make a rational comparison of what is available.

Second, duplicative coverage. One-fifth to one-third of consumers have more than one medigap policy and pay thousands of dollars to buy duplicative coverage. This Committee has expressed concern about a problem of duplication of coverage between Medicare and private policies. Consumers Union does not consider this to be a major problem.

The Catastrophic Act and the National Association of Insurance Commissioners transition rule on Medicare supplement insurance clearly prohibits such duplication. This type of duplication is easy to identify. In contrast, duplication between various Medicare supplement insurance and hospital indemnity and dread disease policies is not presently against the law, is difficult to detect, and as the figures show, is extensive.

Low value. Most policies divert a lot of money to pay administrative costs, marketing costs and profits.

Twisting. High first year commissions provide an incentive for agents to churn or twist their clients from one policy to another.

Deceptive lead card company practices. Lead card companies send deceptive mailings to senior citizens making it appear that they are official government mailings.

I will turn now to our recommendations for congressional action. First, Congress should standardize the Medicare supplement insurance market. Standardization of the market should be the centerpiece of regulatory reform. Under standardization the government would establish uniform definitions for key policy terms and restrict the variations allowed for other insurance policy provisions, such as length of pre-existing condition period.

Policy standardization should be distinguished from minimum standard types of regulation. With minimum standards, insurers are free to offer benefits greater than the minimum standard. Under standardization no such variation is allowed. As part of the standardization package, there should be a prohibition of the sale of duplicative coverage. No person should own more than one Medicare supplement insurance policy.

A number of States, including Massachusetts, Wisconsin and Minnesota, have enacted standardization approaches to regulating this market and these are proving to be both effective in improving market performance and popular with the elderly.

Second, Congress should require that the commission structure for the sale of Medicare supplement insurance policies be level. Third, Congress should establish a comprehensive counseling program for health insurance for the elderly and should encourage the States to do the same. Fourth, the sale of hospital indemnity and specified disease—for example, cancer insurance—should be prohibited to people over 65.

In conclusion, marketing abuses in the Medicare supplement insurance industry continue to victimize the country's senior citizens. Congress should enact legislation that would put an end to these abuses and make it possible for consumers to spend their health insurance dollars effectively.

We appreciate the opportunity to present our views.

[The prepared statement of Ms. Shearer appears in the appendix.]

The CHAIRMAN. Ms. Shearer, I strongly supported provisions to give more educational material to the consumers and I am particularly appreciative of the work your organization has done in developing that kind of educational information. But here I hear you saying that you think there ought to be only one medigap policy that a consumer should buy. What do you think of that, Mr. Pomeroy?

Ms. SHEARER. Could I just interrupt for a second.

Mr. POMEROY. Certainly.

The CHAIRMAN. Okay.

Ms. SHEARER. I am sorry I was misunderstood. I do not mean to say just one. I am talking about looking at what is in the market and providing a range of meaningful choice. For example, three different types of medigap policies should be available, not just one.

The CHAIRMAN. I understand that. As I understood you, you are saying that the consumer should end up only buying one of them. Isn't that correct; isn't that what you are saying?

Ms. SHEARER. That is correct. A consumer should not have more than one medigap policy, yes.

The CHAIRMAN. What do you think of that Mr. Pomeroy?

Mr. POMEROY. I believe regulators would agree that a consumer only needs one medigap policy. We disagree with Consumers Union in believing that there ought to be only three variations of that product available to the market. There is a wide range of need out on the market and products are varied to address various needs. Some products are more appropriate for other people, given varying circumstances.

The CHAIRMAN. Well, let me ask you about this. That is an interesting proposal. I would agree that a consumer probably only needs one medigap policy if it is a full one. But you do not think he is entitled to be a fool and buy two if he wants to? Would you legislate that he can only own one?

Ms. SHEARER. Well, I think what I would do is a number of things. First of all, have a standardized market and comprehensive education and counseling so that a person understands that they do not need more than one. Second, I would have severe penalties on agents who oversell or churn policies.

The CHAIRMAN. Churn.

Ms. SHEARER. Churn or oversell. Often agents will sit down with their clients and say, well, you need this policy because it covers this risk and a second policy to cover another risk.

The CHAIRMAN. That is a tough one to enforce. When you have an agent and you have a customer and they are sitting by the fireplace and the fellow runs the flowers by and lets him smell them, you know, and talking about how sick he is going to be. How one person remembers that conversation and how the other one remembers it. Go ahead.

Ms. SHEARER. Excuse me. There are some steps that can be taken. For example, Congressman Dingell, put together a very comprehensive proposal that would require the agent to ask and to get a written response to several questions. The agent would have to ask: "Are you eligible for Medicaid?" and to require the consumer to write down the answer. The agent would have to ask the consumer whether he or she has other health insurance and get the answer in writing. Without anything in writing, you are right, it is extremely difficult to enforce. But there are some steps that could be taken to help on that.

Mr. POMEROY. Mr. Chairman, insurance regulators are moving to address, and presently have before us, a number of proposals which deal with the concerns that Ms. Shearer has been talking about. One of them is a suitability requirement, whereby the agent is under the obligation to sell only that which is suitable to the prospective insured. The issue then does not become how much insurance can the person load up the individual with, it is what does the individual need given the financial circumstances.

The CHAIRMAN. Well, I certainly agree. I think if consumers have the right policy, they only need one, or they end up with a lot of duplicative services.

Senator Packwood.

Senator PACKWOOD. Ms. Shearer, run by me that opening statement you made again. I think I heard that you like the catastrophic health insurance program and you like the way it is financed, and any new monies we have should be used for children or something else. Did I hear it correctly?

Ms. SHEARER. That is our position; that is right. That is why we supported the principle of having the elderly pay for this benefit. That is right.

Senator PACKWOOD. Do you mean both having the elderly pay for it and having payments skewed—not in a bad sense, but skewed progressively—so that those who have somewhat more money pay a bit more than those who have less money?

Ms. SHEARER. That is right. Our position during the development of the catastrophic bill is that a rough guideline that the Congress should consider was that the maximum premium be no more than four times the average benefits. That is close to what was enacted. We support the progressivity.

Senator PACKWOOD. I cannot find that in your written statement that I have. I heard you say it, but I do not find it in your written statement.

Ms. SHEARER. It was my intention to focus in the written statement on the medigap market primarily but I will submit that in writing in addition if that would be helpful.

Senator PACKWOOD. Well, I will just take it out of the transcript. I just wanted to make sure that I heard what I heard.

Ms. SHEARER. Yes.

Senator PACKWOOD. I think you are the first witness to say that.

Ms. SHEARER. I believe a colleague of mine supported it when he was here last month.

Senator PACKWOOD. What happened to him? [Laughter.]

Ms. SHEARER. He is back home in Texas.

Senator PACKWOOD. I thought maybe he was a prisoner in Beirut or something like that.

I have no other questions. Thank you, Mr. Chairman.

The **CHAIRMAN**. Senator Chafee.

Senator **CHAFEE**. Thank you, Mr. Chairman.

Mr. Pomeroy, I would like to refer you to the top of page 5 in your testimony where you indicate that the increased benefits that are provided under the catastrophic, as far as Part A go, are relatively insignificant—that is, the first day payment, once only, and the extension of the time in the hospital. Do I understand you correctly on that?

Mr. **POMEROY**. To put it in proper perspective, those benefits implemented in 1989 do extend the coverage undoubtedly. They generally have not been enough to offset the other increases in the cost and utilization that private insurers have been paying.

Senator **CHAFEE**. Now one of the things that I am interested in is the loss ratios on medigap policies. It is my understanding that GAO has reported that more than half the policies it surveyed had loss ratios below the target of 60 percent. Do you folks take that into consideration at the National Association of Insurance Commissioners?

Mr. **POMEROY**. Yes, we certainly did, Senator. The issue of using loss ratios is a very useful regulatory tool when evaluating submitted rate increases requested by insurers. It has not been a particularly effective tool to date relative to forcing companies to roll their rates back in the even they are not reaching targeted loss ratios. The reason for that is an actuarial explanation and it involves basically the varying maturity of the risk pool covered.

Unfortunately, our reporting blank did not really ferret out, I think, in appropriate actuarial fashion whether or not they were meeting the targeted loss ratio. We think we will be able to do a better job in 1989 and forward.

Senator **CHAFEE**. I am not sure I quite understand you. Let's say they are below 60 percent, considerably below it, don't you folks then say, okay, reduce your premiums?

Mr. **POMEROY**. Senator, that would be correct in the event it was a mature loss pool. Now the loss ratio will vary on a policy depending on the length of time that——

Senator **CHAFEE**. I see. You have to have some period to examine it?

Mr. **POMEROY**. That is correct.

Senator **CHAFEE**. Okay. Now, Ms. Shearer, you say in your testimony that if you make this voluntary as we have proposed here, that all the healthy would get out of the program and only the unhealthy would be left there. I do not quite understand the rationale there. First of all, I am not sure why so many people would get out of it. Why would they get out of it?

Ms. **SHEARER**. Well, I think that anybody paying the maximum supplemental premium would consider whether it would make sense to buy a private medigap policy to cover the Part B and the catastrophic needs. The private insurers are interested in marketing such a policy, mostly to healthy people. So you have the combined effects: people who are at risk of paying the largest supplemental premium and people who are most eligible for a private policy would be the likely people to withdraw from the Part B and catastrophic program.

Senator CHAFEE. You think they could get a private policy for less money? After all, that would be the inducement.

Ms. SHEARER. Well, that is right. I think in the short term, when they are relatively young, they are close to 65, they are relatively healthy, I believe there would be private insurers who would be willing to market such a policy.

Senator CHAFEE. Oh, you mean restrict it in age from 65 to 70?

Ms. SHEARER. Well, that is one of my concerns, Senator.

Senator CHAFEE. Under our program, I do not think you can get back in.

Ms. SHEARER. Well, I am glad to hear that because that would help provide an inducement. I think there is a lot of misinformation among the public about what the relative efficiency of the Medicare program and about the practices of private insurers in terms of whether their policies are guaranteed renewable, for example.

Senator CHAFEE. Well, I am not positive that under our program you could not get back in. I do not know what the answer to that is.

Ms. SHEARER. It is an important point.

Senator CHAFEE. But that would be an incentive for them to stay in, obviously?

Ms. SHEARER. That is right.

Senator CHAFEE. Okay, fine. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much for your testimony. It was quite helpful.

Our next panel will be Mr. Alan Reuther, who is the associate general counsel of the United Automobile Workers; Mr. Alan Spielman, the executive director of government programs legislation, Blue Cross and Blue Shield; Mrs. Linda Jenckes, the vice president of Federal affairs, Health Insurance Association of America.

We are pleased to have you. Mr. Reuther.

STATEMENT OF ALAN V. REUTHER, ASSOCIATE GENERAL COUNSEL, UNITED AUTO WORKERS, WASHINGTON, DC

Mr. REUTHER. Thank you. Mr. Chairman, my name is Alan Reuther. I am an Associate General Counsel for the UAW. We are pleased to have this opportunity to share with you our views on the issues relating to duplication of health care coverage under the Medicare Catastrophic Protection Act.

Prior to enactment of the catastrophic legislation many employers provided their retirees with health insurance coverage comparable to the benefits provided under the catastrophic program. UAW retirees covered under our collective bargaining agreements with the major automobile, aerospace and agricultural implement companies already had all of the benefits provided under the catastrophic act. These benefits were paid for entirely by the employer.

The enactment of the catastrophic legislation has resulted in a huge windfall for employers which maintained retiree health insurance programs for post-65 retirees and their families. Because the catastrophic program expanded the benefits covered under Medicare, it correspondingly reduced the benefits which have to be covered under these employer-sponsored retiree health insurance programs.

At the same time, the catastrophic act also imposed significant new costs on senior citizens. The net result of the catastrophic program is to provide an economic windfall for many employers and to shift the cost of paying for catastrophic benefits from these employers directly to the elderly. Thus, many retirees are actually worse off as a result of the catastrophic program.

In an effort to address this problem, the Catastrophic act contains the so-called maintenance of effort requirement. Although this provision will provide some relief to UAW retirees and other senior citizens, it does not solve all of the problems created by duplicative health care coverage. To begin with the maintenance of effort provision is only temporary. Once it expires the cost of providing the catastrophic benefits will still be shifted from employers to retirees. Furthermore, there will still be many cases where the basic and supplemental premiums paid by retirees under the catastrophic program will exceed the value of any rebate or additional benefits paid by their employer under the maintenance of effort provision.

To address these concerns the UAW urges this Committee to consider a number of improvements to the maintenance of effort provision. First, it should be made permanent for all persons who have retired. Second, it should apply to all individuals covered under employer-sponsored retiree health plans which provide duplicative coverage, not simply individuals who retired prior to the date the catastrophic program was enacted. Third, it should apply to all of the benefits provided under an employer-sponsored plan which duplicate any of the benefits under the catastrophic act, including benefits under the new prescription drug program. Fourth, the threshold for applying the maintenance of effort obligation should be lowered significantly. And lastly, the law should be amended to make it clear that the maintenance of effort rebates are not subject to Federal income and FICA taxes.

In addition to the foregoing improvements we urge this Committee to explore the possibility of allowing employers in lieu of the maintenance of effort obligation to purchase catastrophic coverage from Medicare on behalf of their retirees. This could be accomplished by having employers pay Medicare on behalf of each retiree an amount equal to the actuarial value of the catastrophic benefits for that year. If an employer chooses this Medicare buy-in option, the retirees would be exempt from the flat premium and surtax levied under the catastrophic program.

There has been considerable discussions about proposals to make the Medicare catastrophic program voluntary. The UAW strongly opposes these proposals. One proposal would allow retirees to opt out of the catastrophic program, but would still permit them to enroll in the Medicare Part B program. The problem with this proposal is that it would almost certainly result in a large revenue loss to the Federal Government, thereby undermining the solvency of the catastrophic program.

Another proposal would allow retirees to opt out of the catastrophic program, only if they also decide to opt out of the Medicare Part B program. The UAW is concerned that the private insurance industry might try to stimulate an exodus from the Medicare Part B and catastrophic programs by feeding on the fears of senior citizens concerning the new surtax. There might also be a significant problem of adverse selection. Most importantly, senior citizens who are covered under certain employer-sponsored retiree health insurance programs could still have an incentive to opt out of both Medicare Part B and the catastrophic programs.

For all of these reasons we are concerned that in the long run this proposal could undermine the social insurance nature of the Medicare program. The UAW also believes that it is wrong to characterize this proposal as making the catastrophic program voluntary. Although senior citizens would have the right to opt out of the catastrophic program, they would be subjected to an extremely heavy penalty if they chose this option. That is, they would also have to opt out of Medicare Part B and lose the subsidized coverage offered under that program.

Prior to the enactment of the catastrophic act all senior citizens had the right to enroll in the Medicare Part B program and all senior citizens received the same subsidy under that program. The proposal to link enrollment in the catastrophic program with enrollment in the Medicare Part B program is simply an indirect means of reducing the subsidy under the Medicare Part B program for middle and upper income senior citizens.

In the past we have consistently opposed proposals to reduce the portion of the Medicare Part B program which is subsidized through general revenues. Accordingly, we also oppose any proposals which would indirectly accomplish the same result by linking enrollment in the Medicare Part B program with enrollment in the catastrophic program.

In conclusion, Mr. Chairman, the UAW appreciates the opportunity to present our views on the problems associated with duplicative health care coverage. We look forward to working with you and the other members of this Committee in dealing with this difficult problem. Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Reuther appears in the appendix.]

The CHAIRMAN. Mr. Spielman.

STATEMENT OF ALAN P. SPIELMAN, EXECUTIVE DIRECTOR, GOVERNMENT PROGRAMS LEGISLATION, BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Mr. SPIELMAN. Thank you, Mr. Chairman. We do appreciate the opportunity to be here and I would ask that my full written statement be included in the record.

The CHAIRMAN. It will be done.

Mr. SPIELMAN. We in the Blue Cross and Blue Shield Association and member plans are proud of the medigap coverage we provide to over 8.5 million senior citizens. Our products provide a wide range of benefits and high value to senior citizens. In 1987 our products returned on average 95 cents in benefit payments for every dollar collected in premiums.

In 1989, our Medigap increases have been quite moderate. On average, the rate increases were about 8 percent and premiums for about 20 Blue Cross and Blue Shield plan medigap policies actually decreased in 1989.

I would like to make several points in this area. First, duplication of coverage between Medicare and medigap should not exist. We believe, Mr. Chairman, that existing law is adequate to prevent such duplication if properly enforced.

Second, duplication among medigap policies should also not exist. But, unfortunately, it does. Some seniors do buy several policies. We all need to do more to get the message across that multiple medigap policies are a waste of money.

Third, there continues to be, as mentioned earlier, wide variation in loss ratio compliance. The GAO study cited earlier indicated loss ratios of less than 60 percent for certain policies provided by our competitors.

What can be done about this? We think several things. First, strengthen the NAIC models. This Committee has recognized the importance of NAIC work in establishing benefit and consumer protection standards. Work is underway now to revise those standards as indicated previously; and we would urge you to support that effort. We are working closely with the NAIC and in late fall or winter they expect to finalize those standards. Those revisions, once adopted, could be also adopted for purposes of the Federal certification program.

Second, we believe that the Federal penalties against duplication should be clarified and any loopholes eliminated. Third, to help reduce duplication, we would urge you to consider strengthening the notice requirements at the point of sale to require a comparison of the new policy, whether it be a medigap policy or a limited benefits policy, with the minimum medigap standards—how it measures up.

We would also urge that at the point of sale consumers be provided with information on the availability of Medicaid coverage of Medicare cost sharing for certain low-income beneficiaries. Finally, we recommend that the notice provide a strong advisory against buying more than one policy that meets the minimum standards.

The final recommendation we have would encourage appropriate enforcement of minimum standards. We recommend that you consider a requirement that States provide assurances satisfactory to the Secretary of Health and Human Services that they have mechanisms in place for reviewing the loss ratios of medigap policies and have taken appropriate action against policies which consistently fail to deliver reasonable value to consumers.

We would be pleased to work with you on these proposals and any other aspects of this issue. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Spielman appears in the appendix.]

The CHAIRMAN. Mrs. Jenckes.

STATEMENT OF LINDA S. JENCKES, VICE PRESIDENT, FEDERAL AFFAIRS, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Mrs. JENCKES. Thank you, Mr. Chairman, and members of the Committee. I would hope, Mr. Chairman, that my entire statement would be put in the record. I would like to begin by saying that we empathize with you.

The CHAIRMAN. I have needed that. Thank you very much.

Mrs. JENCKES. But you are not the only one that is having a difficult time explaining the benefits to Medicare beneficiaries. We, in the insurance industry—whether it is Blue Cross and Blue Shield or other companies that are not members of ours—have literally been inundated with calls from reporters, consumer groups and policyholders seeking information and explanations. I am not sure if anyone quite expected this degree of beneficiary disquiet or confusion.

Industry representatives spent a good deal of time during the consideration of the catastrophic bill working with your Committee, as well as others, The Department of Health and Human Services, as well as the National Association of Insurance Commissioners, to assure a smooth transition for the 70 percent of Medicare beneficiaries who also have private health insurance.

I would like to take note that we have recently revised our Medicare supplement insurance consumer book which we have made available to the Committee and staff. But I would also like to suggest that if you would like additional copies for your constituents we would be happy to provide them. We also have a toll-free 800 number, which has been in existence since 1983 and, as you can well imagine, the number of phone calls has substantially increased with the passage of the catastrophic law.

What I would like to do is just mention that in conjunction with the catastrophic law, there were specific requirements that were put in place by the law for both the National Association of Insurance Commissioners and their respective insurance departments, as well as for insurers. As each State of the benefits are phased in over the next 3 years, private insurers must: (1) inform policyholders of the changes; (2) issue policy riders eliminating duplicate coverage; and (3) commence rate adjustment proceedings with the State insurance departments in order to guarantee that policyholders get appropriate premium adjustment for the amended coverage.

These steps are required for all Medicare supplemental policies in force. Beneficiaries with employer-provided health insurance to supplement Medicare are getting cash rebates or new benefits as required by the maintenance of effort provision of the catastrophic act. I might add that most employers, to our knowledge, are, in fact, giving cash rebates.

Again, to my knowledge, all of the provisions in the catastrophic legislation which set out the steps to be taken by State insurance officials to assure swift and efficient transition have occurred as planned and with little contention. The NAIC has met all of its deadlines for amending its model regulations for Medicare supplemental policies.

In fact, the General Accounting Office and the Health Care Financing Administration, as stated in recent reports to Congress, have concurred that this transition phase has been well done. I even note that the Federal Trade Commission in February of this year indicated that only two complaints on government "look alike" policies have been received on Medicare supplemental policies.

My submitted statement describes the pattern of private health insurance coverage sold to the Medicare population. But I would just like to highlight a few points. Nearly all elderly Americans participate in the Medicare program. Less understood, however, is the extent that the elderly are covered by other health insurance policies—71.5 percent of the 30 million elderly are covered by private health insurance; and another 11 percent have Medicaid.

Employer-sponsored health insurance still plays a major role for many elderly in protecting them against the cost of care. Data from the Employee Benefit Research Institute indicates that about one of every four elderly citizens—7.6 million individuals—have employer-sponsored health retirement benefits. A recent survey of 500 elderly conducted by HIAA in response analysis would place that figure at over 30 percent. Another HIAA survey—and Mr. Chairman, I would like to submit both of these for the record when available; I just happen to have preliminary data on them—indicates that employers pay an average of 85 percent of the cost of single coverage, and 77 percent for family coverage.

[The information appears in the appendix.]

Mrs. JENCKES. Employers also pay full cost of Part B Medicare premiums for over 40 percent of their retirees and 34 percent of their spouses. Benefits in retirement plans are also broad. For example, 94 percent of retirees are covered for prescription drugs and 91 percent have home health coverage. Nearly 90 percent have catastrophic thresholds after which the beneficiary is no longer responsible for copayments.

Our surveys also show that 90 percent—and I need to correct that in my written testimony—of the elderly remain satisfied with both the costs and benefits of their private coverage. Over 80 percent of owners of private policies plan to retain their current policies; only 3 percent plan to drop them; and 15 percent, do not know.

As an aside, I would just like to indicate that our HIAA survey—again, Mr. Chairman, which I will share with the Committee—indicates that only 85 percent of Medicare beneficiaries have one policy; one 15 percent have two or more, which could include employer plans; and only one person—3/10 percent—out of 500 did not know. So we assume that that individual must have had something.

I would like to move on and just mention that there has been raised as a serious problem perhaps some marketing abuses. We would just like to be on record as saying that we feel that those abuses are extremely rare but to whatever extent they do exist they should be eliminated. We want to work with you, as well as the National Association of Insurance Commissioners, to continue to press for changes in State insurance regulations that will help weed out bad apples and promote increased consumer protection.

Perhaps, Mr. Chairman, one last observation for the sake of time and that on why our private sector premiums are rising. I guess the good news in the Medicare catastrophic law—or at least the first phase of it—is that this is the one phase that perhaps had a good financial impact on beneficiaries. This was the change in the number of unlimited hospital days, in terms of Part A, and also in the fact that individuals are now only responsible for one Part A deductible.

Now we estimate that that factor alone represents a potential benefit reduction of 8 to 12 percent. However, unfortunately, on the other hand, a number of premium factors more than offset this reduction. Let me just briefly highlight them. That is the fact that the Medicare Part A deductible, even though now there is only one, was increased from $540 to $560 in 1989. We, based on our past experience, approximate that one-quarter or 8 million of the 32 million beneficiaries will enter a hospital at least once this year. That represents a raw claims cost of $5 per beneficiary.

There are a few other features. But rather than comment on them, I would like to talk about the most compelling one. That is the overall increase in cost to the Part B program. Physician costs, whether it be for Part B and moving to an out-patient basis services, are accounting for approximately a 16 percent increase in Part B costs. We, in the private sector, whether it is Blue Cross and Blue Shield or the commercial insurance industry, pick up these costs—because the second phase the catastrophic law is not in effect—of the 20 percent co-payment, which reflect those increases in Medicare Part B costs.

I would like to conclude, Mr. Chairman, by saying, as you know, we were never supportive of the catastrophic law. We had hoped instead that the Congress could look at long-term care benefits and perhaps include some tax incentives for individuals to purchase long-term care policies.

In yet another survey that I would like to share with the Committee, we have indications that consumers—those over the age of 65 and younger—are in fact willing to pay for the cost of private long-term care policies. We are proud that we and Blue Cross and Blue Shield have been able to put them on the market and we want to pledge to work with you in the future on this as well as the Medicare supplemental problem.

The CHAIRMAN. Thank you, Mrs. Jenckes.

[The prepared statement of Mrs. Jenckes appears in the appendix.]

The CHAIRMAN. Mrs. Jenckes, your number of 85 percent of the cost for single coverage being paid by employers and 77 percent for the family coverage is substantially higher than the number we have received from CBO. I am curious to know —I am trying to find the difference. Is that percentage, does it relate just to the retirees or is that retirees and workers too?

Mrs. JENCKES. Mr. Chairman, that figure is for retirees.

The CHAIRMAN. Would you get me those numbers so we can see where the difference is between you and CBO.

[The information appears in the appendix.]

The CHAIRMAN. Did I understand you to say that your industry is paying back to most employers some reduction in the cost of the premium because of the duplicative coverage?

Mrs. JENCKES. No. Mr. Chairman, what I was suggesting is that one facet of the Medicare Catastrophic Act that did have a potential for reducing premiums was the fact that now the Federal Government would be only requiring the individual to pick up one hospital deductible as opposed to the past.

The CHAIRMAN. All right.

Mrs. JENCKES. However, the offset is based on the fact that the Part B costs continue to rise at a rate which we cannot control. Number two is the fact that many insurers delayed or deferred premium adjustments because of the uncertainty as to what was going to be included in the final catastrophic bill.

The CHAIRMAN. I have heard that. Thank you.

Mr. Reuther, you made a point about making the maintenance of effort on Part A, going through 1989, and Part B through 1990, making that permanent. Doesn't that put us in a situation where you would lock it in permanently for the future for employees after the date of the catastrophic illness bill? Wouldn't it require a minimum in the retiree benefits that would not be reduced in the future? Wouldn't that more or less, if I understand you, lock that in?

Mr. REUTHER. I think there may be some misunderstanding about what we are suggesting. We believe the maintenance of effort provision should be permanent for people who have already retired because under our view, under the law, an employer does not have the liberty to cut back on their benefits. As far as people who retire in the future though, we are not suggesting that it should be made permanent.

The CHAIRMAN. I see. So you are getting, again, to what are different decisions of the courts on the question of those already retired and whether or not those benefits can be changed. That is still in dispute in some of the courts as I understand it.

Mr. REUTHER. That is true.

The CHAIRMAN. Yes.

Senator Rockefeller.

Senator ROCKEFELLER. One question, Mr. Chairman, to Mrs. Jenckes.

You indicated that it might be possible that you had data that indicated people earlier in their lives might be willing to make insurance purchasing decisions with relation to long-term health care which could incorporate certain catastrophic principles and this might work out. This is one of the things we are looking at in the Pepper Commission. The evidence that we are getting, at least as experts speak to us, is that trying to talk to a forty year old about long-term care is terrific, but it does not work. Because when you are forty you are going to live forever. So I am interested in your data.

Mrs. JENCKES. Senator Rockefeller, I would just like to make one response—and I will supply you with the data—is, we were surprised as well. I think you are aware that several of our companies are offering group available—meaning employer-offered, but not financed—long-term care policies. To our utter amazement the evidence is that the average age of sign up is the age of 42.

We feel in part that is a blessing due to the catastrophic law because I think people are now aware, regardless of age, that Medicare does not offer nursing home coverage. We do have statistics to back it up, which I would be happy to give you.

Senator ROCKEFELLER. Thank you.

The CHAIRMAN. Thank you very much for your testimony.

Our next panel consists of Mr. Arthur Flemming, co-chairman of the Save Our Security Coalition and the former Secretary of Health, Education and Welfare; and Ms. Martha McSteen, president of the National Committee to Preserve Social Security and Medicare.

Well, Mr. Flemming, you have been before this Committee many times. We are delighted to have you back. If you would proceed.

STATEMENT OF ARTHUR S. FLEMMING, CO-CHAIRMAN, SAVE OUR SECURITY COALITION, AND FORMER SECRETARY, HEALTH, EDUCATION AND WELFARE, WASHINGTON, DC

Mr. FLEMMING. It is a pleasure to be back, Mr. Chairman. Along with others, I deeply appreciate your willingness to hold hearings on this very, very important issue. As you know, and the other members of the Committee, Save our Security is a coalition of over 100 national, State and local aging and disability groups, founded in 1978 by the late Wilbur Cohen. SOS supports a strong social security and health care system in America.

One of the most active members of the SOS coalition is the United Automobile Workers of America. If you look at the outline of my testimony, which I have submitted for the record, you will note that that outline parallels the recommendations included in Alan Reuther's testimony relative to possible amendments to the maintenance of effort amendment.

We appreciate the fact that that amendment was initiated in the Senate. We feel that the amendments that were suggested by Alan Reuther are amendments that could prove to be very, very helpful in expanding the concept.

Specifically, also, I would like to underline the amendment that he urges the Committee to take a look at which is the amendment that would allow employers, including State and local governments in lieu of the maintenance of effort obligation to make payments to Medicare on behalf of all retirees in lieu of their making the supplemental payments themselves, payments which will be equal to the annual actuarial value of the catastrophic program for which they are now paying, minus the amount of the flat premium in that year.

We feel that if that particular amendment should be passed that it would mean that under this proposal on balance the employer community would not be paying more over any given period of time than they otherwise would pay for these benefits as they would, in effect, simply be making a change in insurance carriers.

Also, the government would not severe a revenue loss because the revenue attained by the employer's purchase of catastrophic benefits from Medicare would offset the loss from the supplemental payments.

We likewise feel that if a decision is made to permit employers, including State and local government, to purchase catastrophic benefits from Medicare we recommend that the following additional steps be authorized: (1) Permit employers who are not currently paying for catastrophic benefits for retirees to purchase these benefits from Medicare in lieu of the retirees making the supplemental payments themselves; (2) authorize the Federal Government as an employer to make payments to Medicare on behalf of all Federal retirees for the catastrophic benefits in lieu of the retirees making the supplemental payments themselves; and (3) similarly, authorize health maintenance organizations to purchase catastrophic benefits from Medicare in lieu of their Medicare beneficiaries making the supplemental benefits themselves.

We feel that if this basic amendment were adopted, and together with these other amendments that have been suggested, that it would not go a long ways in the direction of dealing with what is essentially an inequitable situation, a situation which if it is not correct will undermine confidence in the Federal Government's commitment to fairness.

We recognize that this proposal does not deal with the fundamental issues, namely that improvements in Medicare should be financed by the entire community and not just by beneficiaries.

Next, I would just like to comment briefly on the proposals to make catastrophic programs voluntary. Either one of these proposals, in our judgment, would start the nation down the slippery slope of seriously weakening one of the basic concepts incorporated in our social security program, namely the concept of compulsory and, therefore, virtual, universal coverage.

We feel that this concept of compulsory coverage has brought some genuine benefits to our nation. One of the things it has done is to avoid diluting—when we avoid diluting the concept of compulsory, universal coverage by permitting individuals to voluntarily leave all or parts of the social security system, we have helped to keep the system on a sound financial basis by protecting it against adverse selection.

There is no doubt that the adoption of either one of the proposals that are before the Committee for voluntary withdrawal from the Medicare catastrophic plan would lead to adverse selection. It is clear that the adverse selection would be greater if the beneficiary is not required to also withdraw from Part B. Adverse selection would also be greater if the issue of duplication of payments for catastrophic coverage is not dealt with in an adequate manner.

Even a small step down the slope of a voluntary approach to social security of compulsory or universal coverage, which some may allege these proposals to be, is almost sure to encourage other exception with a resulting serious weakening of the concept. Whenever we narrow the definition of the community participating in any aspect of our social security system we will pay a price—the price of weakening the system.

Dr. Fein, one of the nation's leading authorities in the field of health care in commenting on the method of financing the catastrophic bill says we paid a price—I fear a heavy price—when we redefined community and opted for a financing system in which the group at risk is supposed to finance its own services.

The **CHAIRMAN**. Mr. Flemming, I will have to ask you to summarize, Mr. Flemming.

Mr. **FLEMMING**. I am right at the last sentence, Mr. Chairman.

We would pay a price, a heavy price, if we redefine community by retreating from the concept of universality by authorizing voluntary withdrawals.

Thank you very much.

The **CHAIRMAN**. Thank you.

[The prepared statement of Mr. Flemming appears in the appendix.]

The **CHAIRMAN**. Ms. McSteen.

STATEMENT OF MARTHA McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, WASHINGTON, DC

Ms. **McSTEEN**. Mr. Chairman, as President of the National Committee to Preserve Social Security and Medicare I appreciate the opportunity to present the views of the members, almost 5 million. We would like to thank you very much for addressing this issue and continuing to find ways to resolve some of the problems associated with the Medicare Catastrophic Act.

Prior to the passage of the Act, fully one-fourth of Medicare beneficiaries age 65 and over were covered by health insurance programs provided by current or former employers. That is, in addition to the 50 percent of seniors who had many of the same benefits from their own individual medigap policies and the 10 percent with the lowest income and fewest assets received the same benefits through Medicaid.

It is for the remaining 15 percent of seniors that the Act carries the greatest benefit. To them it is an extension of the nation's safety net. The 1 million beneficiaries who have chosen to become part of risk contract health maintenance organizations are particularly frustrated because they already have catastrophic coverage.

For the 1 million Federal retirees and survivors who are Medicare eligible the catastrophic coverage is also duplicative because they receive such coverage through their health insurance plans.

In the long run, large employers may be the segment of our economy to benefit the most from the Act. The Employee Benefit Research Institute has estimated that the catastrophic legislation reduces employers' liability to current retirees by 30 percent.

In connection with the voluntary coverage, we have been looking at the various pieces of legislation that have been proposed and there is no question that Medicare Part B coverage is valuable and essential for American seniors.

But recognizing the value of Part B, we then must examine how a voluntary catastrophic benefit package tied to Part B would impact the nation's seniors. Just how voluntary would such coverage be? There seems to be really little choice for a natural, unconstrained decision. Dropping Part B would just make seniors worse off. Those opting out would lose valuable Part B benefits while the cost of this protection would undoubtedly increase for those who remain.

Seniors with meager annual incomes would likely be forced to choose between purchasing Medicare coverage and purchasing other necessities such as food and rent. Adding the catastrophic program to Part B places low and middle income seniors in a dilemma. It does not address the true concerns which seniors have raised about the new law.

What is abundantly clear is that those seniors who are most in need of health care coverage provided by Part B and catastrophic are still going to need it, voluntary or not. More than likely these seniors will be the poor and middle income seniors with limited ability to pay. And if wealthy seniors elect to drop from the program, the added cost will fall to those least able to afford it. Clearly, making this program voluntary will increase the cost of these essential benefits for those in these income categories who remain.

The National Committee believes the solution to the questions being addressed here today lies in strongly supporting legislation introduced by Senators Harkin and Levin and Representative Bonior. This legislation replaces the Medicare surtax, retains all benefits offered, including the popular prescription drug provision offered under the catastrophic act, and in the process closes a tax loophole for the wealthy.

The National Committee respectfully requests the Senate Finance Committee to give this legislation favorable consideration. Social insurance programs such as social security and Medicare have always been financed by broad-based revenues rather than user fees, for these programs benefit all Americans not just a few.

Medicare is designed to not only protect seniors and disabled individuals in ill health, but it also promises protection for today's workers and eases the burdens on families of beneficiaries.

Thank you, Mr. Chairman, for this opportunity.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. McSteen appears in the appendix.]

The CHAIRMAN. Ms. McSteen, I understand that you stated that the out-of-pocket costs under Medicare, according to your estimates, would be at least $2,825.

Ms. MCSTEEN. Yes.

The CHAIRMAN. What do you think they would have been without the catastrophic illness bill?

Ms. MCSTEEN. Well, I do not have those figures before me as to what they would be.

The CHAIRMAN. Well, let me tell you what the General Accounting Office testified to. They testified that those costs would be up in the area of $50,000. So obviously, as it is constructed, it does have some very major benefits to the recipients of it.

Ms. MCSTEEN. Yes, we agree.

The CHAIRMAN. Now one of the other problems we have, if you recall, when we were considering this, the Administration—the previous Administration—made it very clear that they were going to oppose it, fight it, veto it, unless those people who were the potential beneficiaries of it paid for it. That is what we faced.

Now you are talking to me about not making Part B voluntary. Your concern there is that we would further erode Part B.

Ms. McSteen. Yes.

The Chairman. And yet the Congressional Budget Office says even those people paying the highest premium will still have a very major subsidy from the Federal Government, meaning the other taxpayers of the country. Am I to conclude from what you say that you think there is not enough support for a catastrophic illness bill, that those people of that age would not support it if they have to pay for it?

Ms. McSteen. There are many benefits in the catastrophic package. There is no doubt about it. I think the concern that members of the National Committee have, and many seniors across the country, is that to deviate from the social insurance concept is quite radical and that we should attempt to stick to the past procedures for providing for social programs that do benefit all Americans, not just seniors. And seniors are taxpayers and seniors do pay their share and they want to pay their share.

It is just that besides the catastrophic coverage, long-term care, as you well know, is out there and is yet to be paid for by someone. I think seniors expect to share a part of that burden also. So it is just a continuance as we move to bring health care to, I hope, all people in this country under some semblance in the near future that we are concerned about.

The Chairman. Mr. Flemming, when you say we get on the slippery slope, aren't we already there with Part B? That is a voluntary program. It is subsidized; it is a question of the degree of subsidizing. When you add catastrophic, the percentage of subsidization is not quite as high, obviously. But aren't we already there?

Mr. Flemming. Already at what point?

The Chairman. Part B is voluntary.

Mr. Flemming. Well, it is true. The history of Part B, of course, is very interesting from my point of view. When those of us who were initially working on Medicare back in the middle 1960s went to work on it we were advocating both Part A and Part B as compulsory programs, as you may undoubtedly know. When the bills started through the Congress it had only a Part A—only hospitalization. That is what came over to the Senate from the House and twice the Senate rejected that bill with only a hospitalization provision in it.

Then people went to work on seeing what they could do about getting some coverage of medical costs into the bill. The voluntary aspect of Part B was a compromise. It was worked out over in the House and that passed and came over here and that passed the Senate. Now it is very interesting, when that was first put into operation, when a person reached 65 they were told that they were under Medicare and then they were told that they had an option of deciding whether or not they wanted to be under Part B. They could say at that particular point they wanted to be under or they did not want to be under.

But Congress later changed that law so as to provide that when a person becomes eligible at 65 for Part A you get a statement saying you are under Part A and the statement says you are also under Part B. That there will be a deduction of your social security check to cover the premiums and so on, unless you say that you do not want to be under Part B.

The CHAIRMAN. Unless you opt out.

Mr. FLEMMING. Unless you opt out. So that when the Congress amended the law at that point, they took one step away from a pure voluntary approach.

The CHAIRMAN. They took an overt act on the part of——

Mr. FLEMMING. Many of us hope that the time will come when the Congress will take the second step. Because we really believe that if our social security system overall, not just the health care, but retirement, survivorship, disability and so on, is going to be on a sound basis it should be on a compulsory basis.

That is why we do not want to see another step taken in what we think is the wrong direction—namely, giving people an option to opt out of a program such as the catastrophic because we really believe that if that option is given there will be the element of adverse selection.

Now nobody knows just to what extent and so on. But that it will be there. Obviously, it would be there if they were not required to also opt out of Part B. But even if they are required also to opt out of Part B, there will be some adverse selection.

Mr. Chairman, personally as one who believes so firmly in this social security concept that we have developed here in this country, I do not want to see us take another step down that, what I call, slippery slope. That is the main point that I would like to make on that.

The CHAIRMAN. Thank you, Mr. Flemming.

Senator ROCKEFELLER.

Senator ROCKEFELLER. Just one question, Mr. Chairman, to Ms. McSteen.

You made the point in your testimony that really the catastrophic health care Medicare bill really only affects about 15 percent of seniors without medigap coverage and then you indicated, I thought, that the other 85 percent were more or less covered.

Ms. MCSTEEN. With some coverage, either medigap or Medicaid—yes.

Senator ROCKEFELLER. Right. Now, then you came along and suggested that the Harkin bill should be supported, which would retain all of the benefits but would be paid for by all of the people.

Ms. MCSTEEN. Right.

Senator ROCKEFELLER. My question is, is there not an inconsistency in that if you say that it really only works for 15 percent, the 85 percent are otherwise covered by medigap, I would have some questions. Other testimony this morning has indicated that there are some major gaps in that medigap coverage.

Ms. MCSTEEN. Right.

Senator ROCKEFELLER. But do I find an inconsistency in your testimony?

Ms. MCSTEEN. The Harkin bill would retain, as you know, all of the provisions of the catastrophic. In my testimony regarding the duplication of benefits I was trying to say that there are 15 percent of the people who would really gain from it a great deal. But certainly, because it does include certain elements of coverage that are not in the Medicare bill now, it would provide coverage for those people, even though some of it is duplicate.

Medigap policies are supposed to adjust themselves to accommodate the catastrophic coverage. In that way then it—the Harkin bill—should protect those people too.

Senator ROCKEFELLER. I see.

Thank you, Mr. Chairman.

Mr. FLEMMING. Mr. Chairman, could I make just one statement?

The CHAIRMAN. Mr. Flemming, I am 40 minutes late. We have a caucus meeting right now.

Mr. FLEMMING. Okay.

The CHAIRMAN. I have been staying here because I wanted to have a chance to hear all of you. I appreciate very much your testimony. Thank you.

Mr. FLEMMING. I appreciate it.

The CHAIRMAN. It has been most helpful to us. Thank you.

Ms. MCSTEEN. Thank you.

[Whereupon, the hearing was adjourned at 12:52 p.m.]

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

SUBMITTED BY SENATOR LLOYED BENTSEN

CONGRESSIONAL RESEARCH SERVICE
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HEALTH INSURANCE THAT SUPPLEMENTS MEDICARE: BACKGROUND MATERIAL AND DATA

INTRODUCTION

On July 1, 1988, the President signed into law P.L. 100-360, the Medicare Catastrophic Coverage Act of 1988 (MCCA). This legislation places an upper limit on the Medicare enrollee's liability in connection with covered Medicare services. It also establishes a new Medicare catastrophic prescription drug program. It has been estimated that once the changes are fully implemented in 1993, approximately 22 percent of Medicare enrollees will be entitled to higher Medicare benefit payments each year.

The legislation is financed through a combination of: (1) an increase in the monthly premium for people enrolled in Part B of Medicare; and (2) a new supplemental premium that is mandatory for people enrolled in, or otherwise eligible for, Part A of Medicare and who have Federal tax liabilities of $150 or more. It is estimated that approximately 41.2 percent of Medicare enrollees will pay the supplemental premium in 1989.

MCCA was designed to address the concern that many of the elderly and disabled covered by Medicare had inadequate protection against catastrophic medical expenses. In fact, about 20 percent of enrollees had no other health insurance coverage. Many of these individuals were poor and near poor not covered by Medicaid.

The majority of Medicare enrollees did, however, have some form of health insurance protection supplementary to Medicare. This paper reviews the types of supplementary coverage held by Medicare enrollees. It also outlines the provisions of MCCA designed to avoid duplicative coverage between Medicare and private policies designed to supplement Medicare's benefits.

Based on 1987 data obtained from the March 1988 Current Population Survey (CPS), 77 percent of the noninstitutionalized Medicare population had some other coverage, either through private insurance or public programs (see table 1).[1] Close to 68 percent of this population had some private health care coverage either through employment-based plans or through individually purchased policies. For the aged noninstitutionalized Medicare population, 78 percent had some form of supplementary coverage; 71 percent had some form of private insurance coverage.

Approximately 29 percent of the noninstitutionalized Medicare population had some employment-based coverage offered either through a current or former employer or union. For 11 percent of Medicare enrollees, the employer paid the entire cost, while for an additional 12 percent of enrollees the employer paid some of the costs. Included in the category of those for whom employers paid some of the costs are people covered under the Federal Employees Health Benefits program (FEHBP).

Approximately 39 percent of the noninstitutionalized Medicare population had individually purchased policies as their only form of private insurance protection in 1987. Some individuals who had employment-based plans may have also purchased such non-employment based coverage; however, this information was not recorded in the CPS.

Some Medicare enrollees receive coverage through other public programs. In 1987, 8 percent of non-institutionalized enrollees were covered by Medicaid. Approximately 1.6 percent of enrollees who had no private insurance or Medicaid coverage received military or Veterans Administration (VA) health care benefits. The CPS survey does not record those with either private or Medicaid coverage who may also have used military or VA benefits.

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[1] This annual survey, conducted by the Bureau of the Census, covers the civilian noninstitutionalized population. Institutionalized elderly and disabled Medicare enrollees, many of whom are covered by Medicaid, are excluded from this discussion.

TABLE 1. Other Health Insurance Coverage of the Medicare Population, 1987
(numbers in thousands)

		Employment-Based Coverage							
	Total Medicare Enrolles a/	Total	Employer pays total cost	Employer pays some of the cost	Employer pays none of the cost	Private, non-employment based	Medicaid	CHAMPUS, VA or military health care	No other coverage
Aged									
Employed	2,756 (100.0%)	1157 (42.0)	504 (18.3)	524 (19.0)	129 (4.7)	1,061 (38.5)	41 (1.5)	35 (1.3)	461 (16.7)
Not employed	24,754 (100.0%)	6925 (28.0)	2587 (10.5)	2864 (11.6)	1474 (6.0)	10,264 (41.5)	1751 (7.1)	360 (1.5)	5455 (22.0)
Total	27,510 (100.0%)	8082 (29.4)	3091 (11.2)	3388 (12.3)	1603 (5.8)	11,325 (41.2)	1792 (6.5)	395 (1.4)	5916 (21.5)
Under 65									
Employed	285 (100.0%)	95 (33.3)	39 (13.7)	49 (17.2)	7 (2.5)	51 (17.9)	47 (16.5)	7 (2.5)	85 (29.8)
Not Employed	2599 (100.0%)	629 (24.2)	218 (8.4)	332 (12.8)	79 (3.0)	395 (15.2)	611 (23.5)	87 (3.3)	877 (33.7)
Total	2885 (100.0%)	724 (25.1)	257 (8.9)	381 (13.2)	86 (3.0)	446 (15.5)	658 (22.8)	94 (3.3)	962 (33.3)
All Enrolles	30395 (100.0%)	8806 (29.0)	3348 (11.0)	3769 (12.4)	1689 (5.6)	11,771 (38.7)	2450 (8.1)	489 (1.6)	6879 (22.6)

a/ The institutionalized, many of whom are covered by Medicaid, are excluded from this survey.

NOTE: This table does not reflect coverage for persons having more than one form of insurance protection. Persons having more than one type of protection are recorded in the column furthest to the left. For example an individual with both employment-based coverage and Medicaid would be recorded as having only employment-based coverage.

Numbers may not add due to rounding

Source: CBO, Preliminary unpublished tables, October 1988, based on March 1988 Current Population Survey.

MEDIGAP POLICIES

A private non-employment based insurance policy is the most common form of additional coverage for Medicare enrollees. A policy that is designed to supplement Medicare's coverage is referred to as a "Medigap" policy.[2] The principal protection offered by the majority of Medigap policies is coverage of Medicare's deductible and coinsurance charges. Some policies cover a limited number of additional services, for example, prescription drugs. The major sources of Medigap insurance are Blue Cross/Blue Shield (BC/BS) plans and commercial insurance companies.

Standards in Effect Before 1989

There are substantial differences in the costs and coverage offered by various private insurance plans. Regulation of private insurance, including health insurance, has by statute and tradition been primarily a State responsibility. State insurance commissioners participate in a voluntary organization known as the National Association of Insurance Commissioners (NAIC). A primary objective of the NAIC is to promote uniformity in State insurance regulation by developing model State statutes and regulations for adoption by individual States.

Concern with marketing and sales abuses in policies sold to the elderly led to the adoption in 1980 of an amendment to P.L. 96-265, the Social Security Disability Amendments of 1980. This amendment (sometimes known as the "Baucus amendment" after Senator Baucus, the chief Senate sponsor) added a new section 1882 to the Social Security Act. Section 1882 established a voluntary certification program for private health insurance policies designed to supplement Medicare. These policies could, at the option of the insurer, be certified by the Secretary if they met certain standards. This certification would inform the purchaser that the policy met minimum governmental standards. The voluntary program applied only in States that failed to establish equivalent or more stringent programs.

To be certified under section 1882, a policy was required to meet or exceed standards set forth in a model regulation approved by the NAIC on June 6, 1979, and incorporated in section 1882 by reference. These standards required such policies to:

- cover all inpatient hospital coinsurance charges, plus 90 percent of covered charges after a beneficiary exhausted his or her hospital benefits;

- cover Part B coinsurance, which could be subject to a $200 deductible and a maximum benefit of $5,000 per year;

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[2] Employment-based policies can also be referred to as Medigap policies if they are designed to supplement Medicare's coverage.

- require that purchasers of a policy have a "free look" period, during which time they could return an unwanted policy for cancellation and receive a full refund of any premium paid; and
- not define preexisting conditions more restrictively than as a condition that was diagnosed or treated within 6 months before the policy's effective date and not deny a claim, on the basis of preexisting conditions, for services furnished more than 6 months after such effective date.

In addition, Medigap policies were required to meet certain loss ratio targets. Loss ratios are the percentage of insurance premiums returned to policyholders in the form of benefits. They are calculated by dividing the amount of benefits paid by the amount of premiums collected. Medigap policies must be expected to pay benefits equal to at least 60 percent of premiums collected for individual policies and 75 percent for group policies.

Section 1882 also established criminal penalties for fraudulent activities connected with the sale of Medigap policies. Actions subject to penalties include making false statements and misrepresentations, falsely claiming certification by the Secretary, selling policies that duplicate Medicare's benefits, and mailing into a State Medigap policies disapproved by that State.

The elderly may purchase policies not meeting the requirements of section 1882; however, such policies may not be marketed as Medicare supplemental policies. Examples include policies for specific diseases (e.g., cancer policies) or hospital indemnity policies (i.e., policies which pay a fixed amount for each day the insured is in the hospital up to a specified number of days.)

Section 1882 does not apply to plans of employers or labor unions.

New Standards Created by the Medicare Catastrophic Coverage Act

Establishment of new standards. MCCA revised the requirements for the voluntary certification program. It provided that if the NAIC amended its model regulation by October 1, 1988 to reflect changes made by the law, then the amended regulation would apply as a standard for certification. The NAIC met this requirement by adopting an amended regulation on September 20, 1988. (See following section on implementation of the new standards.)

The NAIC model standards apply in a State on the earlier of:

- the date the State adopts standards equal to or more stringent than the amended model regulation; or
- one year after the NAIC first adopts the amended regulation (i.e., September 20, 1989).

After the date the NAIC model standard applies in a State, no Medigap policy may be certified by the Secretary and no secretarial certification may remain in effect unless the policy meets the standards of the NAIC model regulation. Similarly, State regulatory programs must meet or exceed the new NAIC standards by that date in order to be found to meet or continue to meet certification standards.

Transition for existing policies. In September 1987, the NAIC adopted a Model Transition Regulation to implement transitional requirements for the conversion of Medigap policies to conform to what at that time were prospective Medicare program revisions. This Transition Regulation (as subsequently amended to reflect MCCA) contains a specific prohibition against covering benefits under Medigap plans that duplicate Medicare's coverage. Further, it requires insurers to notify beneficiaries of policy and premium changes, to file policy riders with the State to eliminate duplication, and to make appropriate premium adjustments in their policies.

MCCA permitted the selling or maintenance of certified policies in States which had not adopted the amended model regulation by January 1, 1989, as follows:

- In States that enacted standards equal to or more stringent than the NAIC Transition Regulation by January 1, 1989, insurers were required to notify policyholders at least 30 days before the annual effective date of benefit changes required by the new Medicare law.
- In States that had enacted the NAIC Model Regulation but not the NAIC Transition Regulation by January 1, 1989, insurers were required to send a notice to each policyholder by January 31, 1989 explaining the improved Medicare benefits and how these improvements would affect the policy's benefits and premiums.
- In States that had not enacted either the NAIC Transition Regulation or the NAIC Model Regulation by January 1, 1989, policies issued before that date were deemed to be in compliance if the insurer complied with the amended NAIC Model Transition Regulation by January 1, 1989. For policies issued on or after January 1, 1989, (but before the effective date of the Transition or the amended Model Regulation in the State) insurers must be in compliance with the NAIC Transition Regulation before the date of sale.

Other requirements. MCCA contained a number of additional amendments to section 1882 requirements, including the following:

- Free-look. A 30-day free-look period is required for all supplemental policies without regard to the manner in which the purchase of the policy was solicited. (Previously a free-look requirement applied only to mail order policies.)

- Reporting of information. States with their own Medigap certification programs are required either to use forms developed by the NAIC to collect information on actual loss ratios or provide for monitoring of such ratios in an alternative manner approved by the Secretary.

- Consumer information. The Secretary is required to: (1) inform beneficiaries about marketing and sales abuses subject to sanctions and the manner in which they may report any such action or practice; (2) publish a toll-free telephone number for such individuals to report suspected violations of the laws relating to Medigap standards; and (3) provide beneficiaries with a listing of State and Federal agencies and offices where information and assistance relating to Medigap policies may be obtained.

- Required submission of advertising. Entities issuing Medigap policies are required to submit a copy of each advertisement used (or, at State option to be used) to the Commissioner of Insurance (or comparable officer) for review and approval, to the extent required under State law. This provision applies to written, radio, and television ads.

Status of Implementation of the New Standards

NAIC Model Act and regulation. On September 20, 1988, the NAIC adopted modifications to the Medicare Supplement Insurance Minimum Model Standards Act and the amended Model Regulation to implement that Act. The following highlights the major changes contained in these documents:

- The Model Act and Regulation exclude application to plans of employers or labor unions;

- The Model Act and Regulation specifically prohibit duplication of Medicare benefits;

- The Model Act and Regulation requires every insurer or other entity providing supplement insurance or benefits in the State to provide a copy of any advertisement intended for use in the State to the Commissioner of Insurance for review or approval (to the extent required under State law);

- The Model Act and Regulation specify that subscriber contracts of hospital and medical service associations and health maintenance organizations (HMOs) that are designed primarily to supplement Medicare's benefits are included within the definition of Medicare supplement policies;

- The Model Regulation requires insurers to notify policyholders, at least 60 days in advance of the effective date of the new benefit changes, of the appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the policies. Premium adjustments are to be in the form of refunds or premium credits. No other premium adjustment can be made at any time other than the anniversary or renewal date.

- The Model Regulation specifies that the following minimum benefit standards apply:

  - Coverage of either all or none of the hospital deductible;

  - Coverage of the daily copayment charge (i.e., for the first 8 days) for skilled nursing facility (SNF) services;

  - Coverage of the blood deductible under Part A;

  - Effective January 1, 1990, coverage of Part B coinsurance up to the catastrophic limit;

  - Effective January 1, 1990, coverage of the Part B blood deductible;

  - Effective January 1, 1990, coverage for the 20 percent coinsurance for home IV drugs subject to the drug deductible; and

  - Effective January 1, 1990 coverage for the coinsurance for covered immunosuppressive drugs.

The NAIC minimum benefits do not require the coverage of prescription drug expenses incurred by the beneficiary before satisfying the deductible. Further, with the exception of the coverage of coinsurance for home IV drugs and immunosuppressive drugs as noted above, no coverage is required for drug coinsurance charges imposed once the beneficiary has met the drug deductible. Coverage for coinsurance for home IV drugs is limited to drugs subject to the deductible; the deductible does not apply in cases where the drug is furnished in connection with home IV therapy services initiated in the hospital.

State that have taken action. The NAIC reports[3] that all States either have adopted or are in the process of adopting the Model standards. As of

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[3] Testimony of the NAIC before the House Energy and Commerce Committee, Apr. 26, 1989.

April 26, 1989, the following 34 States and the District of Columbia had adopted the new standards:

Alaska
Arizona
Arkansas
California
Colorado
District of Columbia
Georgia
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Maine
Maryland
Massachusetts
Minnesota
Mississippi
Nebraska
Nevada
New Jersey
New Mexico
New York
North Dakota
Ohio
Oregon
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Washington
Wisconsin

Characteristics and Data on Medigap Plans

Loss ratios. In 1986, a General Accounting Office (GAO) report[4] on Medigap insurance concluded that the Baucus amendment had accomplished its primary goal of increasing and standardizing State regulation of Medigap policies. At that time, 46 States, the District of Columbia, and Puerto Rico had laws and/or regulations that met the Baucus requirements.[5]

GAO found that while many individual policies did not meet the target loss ratios of section 1882, the actual loss ratios of the policies with the largest volumes of premiums collected were above the targets. The 1984 aggregate loss ratio for surveyed BC/BS organizations was 81.1 percent. The figure for commercial companies was 60.2 percent; this figure was substantially influenced by the high ratio (78 percent) of Prudential which accounted for nearly one-quarter of premiums collected.

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[4] U.S. General Accounting Office. *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies.* Report to the Subcommittee on Health. House Committee on Ways and Means. GAO/HRD-87-8, Oct. 1986.

[5] The four States not certified as meeting the requirements were Massachusetts, New York, Rhode Island, and Wyoming; regulations of the noncertified States did not include many of the minimum standards, but some included features that exceeded the NAIC model in some respects. According to information obtained in a telephone conversation with an official of HHS, these States were still not certified by Nov. 1, 1988. The Secretary had not certified any policies in these States under the voluntary certification program. Two policies were submitted for approval and were returned to the insurance companies for modifications. The policies were never resubmitted by the insurance companies.

In testimony before the Senate Finance Committee on June 1, 1989, GAO provided the latest available loss ratio information. Information had been obtained for 92 commercial policies, 75 BC/BS individual plans and 47 BC/BS group plans. The 1987 loss ratios for commercial plans was 74 percent. Prudential's high loss ratio of 83 percent helped raise the overall total; excluding Prudential, other commercial policies averaged 59 percent. Loss ratios for the 75 individual BC/BS plans averaged 93 percent while the 47 group plans from those same BC/BS organizations averaged 96 percent. GAO reported that the Medigap policies surveyed had a total of about $4.9 billion in premiums in 1987. Commercial policies had over $1.7 billion; the individual BC/BS plans had $2.6 billion, while the group plans had $0.6 billion.

Policy coverage and conditions. Among Medigap policies, coverage differs substantially. Many provide coverage in addition to the minimum required by the NAIC standards. In its June 1989 issue, *Consumer Reports* reported on its survey of Medigap policies being offered this year. All of the surveyed policies covered the hospital deductible, a number covered skilled nursing facility benefits above the 150 day limit; a number also covered a portion of balance billing charges. The article noted that policies generally will not pay for the kinds of services that Medicare will not cover (such as long-term institutional care); however, a number of the surveyed policies offered what was described as a substantial out-of-hospital prescription drug benefit.

Some of the policies surveyed by *Consumer Reports* included additional restrictions, such as waiting periods for pre-existing conditions. While about half of the companies represented in the survey accepted all applicants, some companies required them to meet certain standards. Premiums for some policies depend on the policyholder's age, while in other cases all persons are charged the same amounts. Some policies are guaranteed renewable for the life of the policyholder. Other policies are conditionally renewable, i.e., the company can cancel so long as it does so for an entire class of policies in the State.

Premiums. Despite the enactment of MCCA, premiums for Medigap policies generally have risen this year, although there is substantial variation among policies and among regions. The BC/BS Association reports that a recent survey of its plans showed that the average annualized rate change for Medicare supplemental subscribers since July 1, 1988 (the enactment date of MCCA) was 8-1/2 percent.[6] The Health Insurance Association of America reported that while commercial insurers do not report their premium rates to the Association, the average increases would appear to be about 10 percent.[7] The increases are attributable to a number of factors including:

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[6] Testimony of the Blue Cross/Blue Shield Association before the House Energy and Commerce Committee, Apr. 6, 1989.

[7] Testimony of Health Insurance Association of America before the House Energy and Commerce Committee, Apr. 6, 1989.

- only the Part A benefit improvements contained in the MCCA were effective this year;
- the timing of the premium adjustment may have coincided with a normal request for a rate increase;
- higher medical care prices and utilization have increased health insurance costs generally;
- some companies that previously used a single rate for each of their standard supplement policies (for example Prudential) have moved to area specific ratings; and
- some companies may be adding the new minimum benefits (such as the deductible) as well as other coverage not previously provided.

Both the coverage offered and the associated premiums vary substantially among insurance policies. Annual premiums for the most generous policies surveyed by *Consumer Reports* were about $1,000 while certain policies rated as "Best Buys," with somewhat less comprehensive coverage, would cost about $600.

Sales Practices by the Industry

The Baucus amendment was enacted in response to widespread reports of abusive sales practices in Medigap policies sold to the elderly. It is generally believed that these practices have diminished since enactment of that law. However, violations still occur. Recent testimony by consumer groups and attorneys before the House Energy and Commerce Committee in April 1989 and similar testimony by the Southwest Regional Office of Consumers Union before the Senate Finance Committee in June 1989 cited a number of recent violations. The types of abusive sales practices cited by these witnesses include the following:

- misrepresentation;
- selling policies which duplicate coverage the senior already has;
- twisting (where agents encourage the elderly to switch, or "twist," old policies for new ones because of the substantially higher commissions on new policies);
- generating lists of names to sell to insurance agents ("lead developing") through ads offering information about Medicare; and
- selling low value hospital indemnity policies or dread disease policies to persons who already have Medicare and Medigap;

The NAIC, in its testimony before the Energy and Commerce Committee, agreed that some abuses still occur. However, it stated that the incidence was considerably less than it was 8 years ago when the Baucus amendment was enacted or even 3 years ago because of the efforts of State insurance commissioners and the NAIC. It noted that in the 11 States that specifically track Medicare supplement complaints, 8 reported less than 10 percent of insurance complaints relating to Medicare supplement policies while 3 States reported a figure slightly over 10 percent.

The NAIC cited a number of recent actions designed to curtail abusive activities including:

- extensive consumer education activities on the part of the States;
- State action barring and penalizing agents for selling duplicative coverage;
- NAIC restriction on payment of first year commissions for replacement business; and
- adoption of *NAIC Rules Governing Advertisements of Medicare Supplement Policies* that include restrictions on celebrity advertising.

EMPLOYER-BASED PLANS

Many employers provide health benefits to their retired and disabled workers. Typically they are medium and large size firms. Although coverage varies, generally it falls into one of the following forms:

- The plan has the same coverage for retirees as for active workers, but subtracts what Medicare pays. This means the retiree must meet at least the employer plan's annual deductibles and coinsurance. This arrangement is often referred to as a *Medicare carve out*;
- The plan pays the difference between what Medicare pays and the employer plan's total covered expenses. This means that Medicare and the employer plan together pay for virtually all the retiree's covered medical expenses. This arrangement is often referred to as a *coordination of benefits* approach;
- The plan pays an amount approximately equal to Medicare's deductibles and coinsurance. This means that Medicare and the employer plan together pay for virtually all of Medicare-covered services. This arrangement is often referred to as a *Medicare supplement*;
- No health insurance is provided, but the employer pays the Medicare Part B premium.

Employer-based group health benefit plans are not covered by the section 1882 standards governing private medigap policies, but various other Federal requirements apply to them.

Requirements for Employer-Based Plans

Generally, when employers provide health benefits to retired and disabled workers also covered by Medicare, Medicare is the primary payer of dually-covered health services. In the absence of other changes, the new benefits offered under MCCA would increase the duplicative coverage for Medicare enrollees covered under employer-based health plans.

MCCA, as amended by P.L. 100-485 (the Family Support Act of 1988), includes a so-called "maintenance of effort" provision. Employers who on enactment (i.e., July 1, 1988) provide health care benefits to employees or retired former employees that duplicate by at least 50 percent the new Medicare Part A benefits must provide to these employees or former employees an amount of additional benefits or refunds, or both, that total at least the actuarial value of the duplicative Part A benefits. Similar requirements are applicable to duplicative Part B benefits. Duplicative benefits are defined as those which are duplicative of the new benefits added by MCCA (excluding covered outpatient drugs). Duplicative benefits are to be determined net of any premiums paid by employees or retirees that are attributable to the duplicative benefits.

The maintenance of effort requirements are time-limited. The requirements with respect to duplicative Part A benefits are effective during 1989 only and for duplicative Part B benefits during 1990 only. Special provisions apply if there is a collective bargaining agreement in effect on the date of enactment. In this case, the requirements are in effect through the end of 1989 for Part A benefits and the end of 1990 for Part B benefits, or if later, the expiration date of the agreement (without regard to extensions after enactment). The law contains no enforcement or penalty provisions. There is no maintenance of effort requirement after expiration of these provisions.

Employers covered by the Part A maintenance of effort requirement are those who, on enactment, provide duplicative Part A benefits whose actuarial value is at least 50 percent of the 1989 national average actuarial value (discounted to the date of enactment) of such new Part A benefits. Similarly, employers covered by the Part B maintenance of effort requirement are those who, on enactment, provide duplicative Part B benefits whose actuarial value is at least 50 percent of the 1990 national average actuarial value (discounted to the date of enactment) of such new Part B benefits. Public employers, except the Federal Government, are included.

An employer may elect to compute the amount of the required benefits or refunds to be provided with respect to duplicative Part A or Part B benefits either:

- as being equal to the respective national average actuarial values of the new Part A or Part B benefits published by the Secretary; or

- the actuarial value with respect to that employer, computed using guidelines published by the Secretary.

The Secretary is required before the beginning of each of 4 years (beginning with 1989 for Part A and 1990 for Part B) to:

- calculate and publish the national average actuarial value of the new benefits for the following year which will be used by employers who elect to use the national figures; and

- publish guidelines to be used by employers who elect to use their own actuarial values.

The Secretary is also required (before 1989 for Part A benefits and 1990 for Part B benefits) to publish guidelines to assist employers in determining whether the maintenance of effort requirements are applicable to them.

The provision does not apply to duplicative benefits provided under a plan:

- to which more than one employer is required to contribute; and
- which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

It should be noted that some current employer plans provide relatively extensive coverage at relatively little cost to retirees. Some of these individuals will now be liable for the Medicare supplemental premium; they may therefore pay more in total than they previously paid for their health insurance coverage.

Exemption for Plans that are Primary Payers

Medicare is the primary payer for aged retirees who have other health insurance coverage; however, Medicare becomes the secondary payer for certain aged workers. Employers are required to offer their employees age 65 or over and to spouses age 65 or over (of employees of any age) the same health benefit coverage offered to younger workers. Employees have the option of accepting or rejecting the employer plan. When a Medicare-eligible employee accepts the employer plan, that plan becomes the primary insurer. Medicare will make secondary payments if the plan pays only a portion of the charges for covered services and primary payments for Medicare covered services not covered under the employer plan. This provision is sometimes referred to as the working aged provision.

For 1987-1991, similar requirements apply to disabled employees (or disabled family members of current employees) of large employers. Large employers are defined as those with 100 or more employees.

Medicare also becomes the secondary payer for a period of up to 12 consecutive months for individuals who are entitled to Medicare solely on the basis of end-stage renal disease and who are entitled to benefits under an employer group health plan.

The maintenance of effort provisions make no specific reference to persons covered under these employer-sponsored plans. However, the conference report on P.L. 100-485 includes the following statement:

> It is the conferees' understanding that in the case of an employer who is a primary insurer for a Medicare beneficiary the maintenance of effort provision does not apply for that employer for such

beneficiary because Medicare is the secondary payer for such beneficiary.[8]

The Congressional Budget Office (CBO) estimates that 3.3 percent of the Medicare population has primary coverage under employer-based plans.[9]

Status of Implementation of New Requirements

On December 6, 1988, the Secretary published a Notice in the *Federal Register*[10] announcing the national average actuarial value of the additional Medicare Part A benefits available in 1989. The 1989 value of the new benefits is $65. The July 1, 1988 value was $61; 50 percent of this value was $30.50. A comparable Notice with respect to duplicative Part B benefits will be published at the end of 1989.

Under the Notice, employers are required to determine if they provided on July 1, 1988, duplicative Part A benefits of $30.50 or greater. If so, they are required to determine the duplicative value for 1989. The employer has the option of using this 1989 value or the 1989 national average actuarial value of duplicative benefits (i.e., $65) to determine the amount to be returned to the beneficiary in the form of a refund or expanded benefits. The Notice provides instructions for making these calculations.

The Notice states that the term "actuarial value" refers to the value of the benefits to the employee, rather than the cost to the employer. Thus, administrative and overhead costs are excluded.

If an employer provides only new benefits, a wide range of benefits may be included. They may include payment of the Part B premium, provided the employer was not already paying the Part B premium as of July 1, 1988. Further, if an employer had already agreed to an increase in benefits prior to July 1, 1988, which were to become effective on or after that date, they are not considered to be additional benefits.

If an employer decides to make only a refund of money, the refund must be available to the beneficiary by the end of the calendar year. Each employee and retiree enrolled in the employer plan is to receive an equal refund. The employer may make part or all of the refund in the form of an offset against employee premiums. An employer may not increase the cost of plan benefits to employees or reduce the amount of plan benefits to offset the cost of additional benefits and/or refunds.

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[8] U.S. Congress. House. *Family Support Act of 1988*. Conference Report to Accompany H.R. 1720. House Report No. 100-998, 100th Cong., 2nd Sess. Washington, U.S. Govt. Print. Off., Sept. 28, 1988. p. 197.

[9] Unpublished CBO data, Nov. 25, 1988.

[10] *Federal Register*, v. 53, no. 234, Dec. 6, 1988, p. 49233.

If an employer chooses to provide a package of additional benefits or a combination of additional benefits and refunds, the employer is required to take into account the timing of changes in the calculation of benefits and refunds. For example, if the employer establishes an additional benefit package for duplicative Part A benefits, effective July 1, 1989, it must either provide appropriate refunds for the first 6 months or ensure that the additional benefits beginning July 1 equal in value 1 year's duplicative benefits.

The Notice specified that the maintenance of effort requirement does not apply to plans where Medicare is the secondary payer.

Characteristics and Data on Employer-Based Plans

Data on the prevalence and nature of employer-based health benefit coverage pertaining to retirees and the disabled is somewhat limited. It is mostly from surveys intended to address broader questions about employee benefits. Thus, many relevant details about how these plans operate with respect to the retired and disabled populations are not available (or are not necessarily conclusive).

One recent source of information is a periodic survey of employee benefit practices of medium and large companies conducted by the consulting firm Hay/Huggins Company, Inc. In its 1988 report,[11] Hays/Huggins indicated that 77 percent of the 656 employers who responded to questions about retiree health benefits said that they provided some sort of health care coverage to their retirees. Five percent reported that they provided it to early retirees only, 11 percent reported that they provided it to "normal" (i.e., age 65 and over) retirees only, and 61 percent reported that they provided it to both early and normal retirees. Somewhat similar results, not yet published by Hay/Huggins, will appear in its upcoming 1989 report. The following table, indicating the prevalence of various types of arrangements for retirees, shows the results of the latest survey.

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[11] *The 1988 Hay/Huggins Benefits Report.* Hay/Huggins Company, Inc. 1988.

TABLE 2. Prevalence of Various Types of Private Employer-Based Health Benefit Plans for Retirees Found in Hay/Huggins Survey, 1989

Employer provides benefits that augment Medicare	Employer reduces own plan $1 for $1 for Medicare	Employer only buys Part B	Employer offers no plan to retirees
45%	25%	5%	25%

Source: Hay/Huggins Company, Inc. Unpublished survey data.

Most private employer plans provide at least the same level of coverage (when Medicare benefits are included) for retirees as for active employees. In the 1988 Hay/Huggins survey, 81 percent of 461 respondents that cover retirees over age 65 described their plans as such. Typically, the plans are of the *carve out* form, where the plan provides the same benefits to retirees as active workers subtracting any Medicare benefits that are paid.[12] Approximately 11 percent of 627 respondents said they paid the Medicare Part B premium for their retirees as part of their plan.

Slightly over half of the respondents reported paying fully for the cost of coverage for retirees over age 65. Slightly over one-third said that they paid fully for dependents' coverage. The remainder reported either sharing the cost with retirees or requiring them to pay for it by themselves.

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[12] Melbinger, Michael S., and Timothy O'Donnell. *The Medicare Catastrophic Coverage Act of 1988 and Its Impact on Employer-Sponsored Retiree Medical Plans*. Employee Relations L.J., v. 14, no. 3, winter 1988. This article cites some statistical data on the prevalence of the various types of retiree health benefit plans reported in 1987 by the consulting firm, Mercer-Meidinger-Hansen, Inc.

TABLE 3. Financing of Private Employer-Based Health Benefit Plans for Retirees Found in Hay/Huggins Survey, 1988

	Percentage of plans reporting method of financing:	
	Retirees under age 65	Retirees age 65 and older
For retirees:		
Fully paid by employer	51%	52%
Shared by employer/retiree	32	28
Paid by retiree	17	20
For dependents of retirees:		
Fully paid by employer	36	38
Shared by employer/retiree	43	37
Paid by retiree	21	35

Source: *1988 Hay/Huggins Benefits Report.*

The Hay/Huggins survey data do not represent a scientific sample. However, they are consistent in various respects with a 1987 survey of employee benefits conducted by the Bureau of Labor Statistics (BLS). That survey, covering medium and large firms with a representative population of 21.3 million full-time workers, showed that, in 1986, 76 percent of the workers were in plans where health benefit coverage extended into retirement (see the following table). It found that where such coverage was provided, it almost always continued up to age 65, and in 90 percent of the cases, it continued after age 65. Employers provided the coverage at no cost to about half of the retirees (although the study found that there had been a notable decline in no-cost coverage from 1980 to 1986) but required about 15 percent of retirees to pay the full cost. Employers shared the cost with about 30 percent of retirees under age 65 and about 22 percent of those age 65 and older.

TABLE 4. Prevalence and Financing of Private Employer-Based Health Benefit Plans for Retirees Found in BLS Survey, 1987[a]

Survey participants:

With retiree coverage	76%
Without retiree coverage	21%

Type of coverage in plans with retiree health benefits:

	Percent of retirees	
	Under age 65 with	Age 65 and older with
Total with coverage	99%	90%
Same coverage as workers	(78)	(71)
Reduced coverage	(18)	(16)
Increased coverage	(1)	(1)
No coverage[b]	1	10
Financing of retiree health benefits:		
Fully paid by employer	51	52
Shared by employer/retiree	30	22
Fully paid by retiree	15	14

[a] Totals may not equal 100 percent because some plans' provisions were not determinable.

[b] Retiree coverage is provided in one of these age groups but not the other.

Source: U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in Medium and Large Firms, 1986.* Bulletin 2281, June 1987.

While the BLS study found that retirees' health benefits were generally the same as workers' benefits, 18 percent of retirees under age 65, and 16 percent of retirees age 65 and older, received reduced coverage. Also, a 1988 survey conducted by another benefit consulting firm, the Wyatt Company, found that one quarter of the companies responding said that they had modified their retiree health plans or anticipated doing so during the next

year. Six percent had already taken action to reduce or eliminate future retiree medical benefit liabilities.[13] This trend is expected to continue because of ongoing efforts by employers to pare their health benefit costs, particularly those incurred on behalf of retirees.

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[13] Wyatt Company. *Retiree Medical Plans: Problems on the Horizon*. The Compensation and Benefit File, v. 5, Jan. 1989. p. 10.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Under FEHBP, Federal employees, retired and disabled annuitants, and their dependents are offered health benefits from a range of participating health benefit plans. The premiums are shared by the Federal Government and by the enrollees.[14] Premium payments are deposited in the Employees Health Benefits Fund, from which benefits and administrative costs are paid. The program is administered by OPM.

FEHBP Coordination with Medicare

FEHBP does not offer plans that are limited to supplementing Medicare's coverage. Retired, disabled, and surviving Federal annuitants enroll in FEHBP under the same coverage options (i.e., for Self Only or Family coverage), pay the same premiums, are included in the same risk pools, and, except for those with Medicare, receive the same benefits as active workers.[15]

Federal annuitants obtain eligibility for Part A of Medicare the same way as other retired and disabled people--either by having worked in employment covered by the Hospital Insurance (HI) portion of the social security payroll tax (as of 1983 virtually all Federal employment became covered) or as a spouse of someone who has earned such coverage. Similarly, their enrollment in Part B is voluntary as it is with most other Part B enrollees. Except for differences in the way supplemental premiums for Medicare catastrophic coverage are calculated (discussed later), FEHBP annuitants with Medicare are generally treated the same under Medicare as are all other Medicare enrollees.

Since most medical services are covered by both programs, Medicare and FEHBP coordinate their benefit payments. By law, Medicare is the "primary payer" (unless the FEHBP annuitant is still employed) as is the case for retirees covered by private plans. In addition, OPM requires, for FEHBP enrollees entitled to Medicare, that each health insurance plan participating in FEHBP waive its hospital and/or medical deductibles and coinsurance. Thus, FEHBP annuitants with Medicare have virtually 100 percent coverage of services covered by their FEHBP plans--an arrangement similar to the so-called *coordination of benefits* plans found in the private sector.

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[14] The non-postal Federal contribution cannot exceed a specified dollar amount or 75 percent of the premium cost, whichever is less. In 1989, the maximum monthly government contribution will be $98.45 for Self Only coverage and $215.54 for family coverage. The average government contribution will be $157.09 and the average enrollee contribution will be $89.57. (Source: OPM.)

[15] To enroll, an annuitant must have participated in FEHBP (1) during the 5 consecutive years before retirement, or (2) for all service since their first opportunity to enroll. Annuitants who cancel their FEHBP coverage cannot later re-enroll in the program.

Although the new Medicare catastrophic benefits may provide additional coverage for annuitants enrolled in the few FEHBP plans that have significant gaps in their catastrophic coverage, it probably will have little effect on the benefits of most FEHBP enrollees. Many of these new Medicare benefits would have been paid by FEHBP, so to a large extent the new catastrophic coverage merely shifts costs from one Government program to another. This was recognized when the new law was formulated, and a provision was included requiring that FEHBP enrollees with Medicare receive a rebate equal to the value of those new Medicare benefits that duplicate FEHBP's.

Rate reduction. The law requires OPM, in consultation with carriers offering benefits under FEHBP, to reduce rates charged to persons who are also covered by Medicare. The reduction is equal to the amount (prorated for each covered Medicare eligible individual) of the estimated cost of the new benefits.

A Medicare eligible individual is defined as any annuitant, survivor of an annuitant, or former spouse of an annuitant who is: a) eligible for FEHBP benefits, b) eligible for Part A benefits, and c) covered by Part B. Further, Medicare must be the primary source of health care benefits for such individual.

Funds in the Employees Health Benefits Fund are available without fiscal year limitation for costs incurred by the OPM in making the rate reduction.

The Director of OPM determined that the premium reduction for 1989 would be $3.10 per month for each eligible FEHBP participant.[16] This reflects the value of the new duplicative Part A benefits in that year. The rebate is added to the retiree's check. GAO recently reviewed the calculation and concluded that it was reasonable.[17] The value of the duplicative benefits (and therefore the rebate) would be expected to rise in the future, particularly in light of the fact that the 1989 amount does not include any Part B and drug benefits since those aspects of the new law do not take effect until 1990 and later years.

OPM Study. The law required OPM to conduct a study regarding changes to FEHBP that may be required to incorporate plans designed specifically for Medicare-eligible individuals and to improve the efficiency and effectiveness of the program. OPM was required to submit a report to the Senate Committee on Governmental Affairs and the House Committee on Post Office and Civil Service by April 1, 1989. Any supplemental plan recommended by the OPM was not to duplicate benefits for which payment may be made under Medicare. Any recommended plan had to cover Medicare's coinsurance and deductible charges and could offer additional payments for uncovered benefits or for covered benefits whose Medicare payments are limited by a fee schedule.

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[16] *Federal Register*, v. 53, no. 207, Oct. 26, 1988, p. 43308.

[17] U.S. General Accounting Office. *U.S. Employee Health Benefits. Rebate of Duplicative Medicare Coverage*. GAO/HRD 89-58, Mar. 1989.

OPM also was required to report to the appropriate committees of Congress by April 1, 1989, whether it is feasible to adopt the standards issued by the NAIC (pursuant to the requirements described above) for supplemental policies provided under FEHBP.

A report on these two issues was transmitted to the Committees in May 1989.

Characteristics and Data on FEHBP Coverage of Annuitants

Of 4 million Federal workers and annuitants (i.e., civil service retirees and survivors) enrolled in FEHBP in 1989, an estimated 1.5 million (38 percent) were annuitants. An additional half million annuitants were not enrolled in FEHBP.[18]

OPM estimates that 783,000, or 51 percent, of Federal annuitants enrolled in FEHBP and 351,000 spouses had Medicare Part A protection. An estimated 791,000 annuitants had Part B protection (as did an additional 350,000 spouses). Approximately 60,000 of these annuitants (and 27,000 spouses) had only Part A coverage; some 68,000 of them (and 26,000 spouses) had only Part B coverage.[19]

OPM further estimates that of the 1 million annuitants over age 64, an estimated 760,000, or 76 percent, were eligible for Part A.[20]

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[18] These estimates were prepared by the Congressional Research Service (CRS) using unpublished OPM data. About 45 percent of nonenrolled annuitants waived FEHBP coverage--many of them presumably are in some other medical plan (e.g., a spouse's plan, another employer's plan, a private policy etc.)--and the rest are ineligible.

[19] U.S. Office of Personnel Management. *A Report on Offering Medicare Supplemental Plans to Federal Annuitants.* May 1989.

[20] Ibid.

Measures of Fairness and Duplication of FEHBP Coverage of Annuitants

Two recent reports requested by Congress addressed the question of the fairness of FEHBP to Federal annuitants and the extent to which it duplicates coverage provided under Medicare.

OPM study. As required by the MCCA, OPM studied the idea of offering Medicare supplemental plans under FEHBP to Medicare-eligible enrollees. While the report illustrated a number of possible approaches, OPM concluded that it would not be desirable to create such plans until the more fundamental problems currently affecting FEHBP were "addressed and corrected." The report stated:

> It is our considered opinion that while Medicare supplemental plans may offer the eligible population simpler, more stable and more appropriate coverage, an isolated action to remove these enrollees from the general risk pool would increase Government costs, increase costs to many (and the most vulnerable) enrollees, and quite possibly destabilize the entire program with consequences not entirely foreseeable.[21]

The report also concluded that if a supplemental plan were adopted for FEHBP enrollees with Medicare, it would be feasible to conform it to the NAIC standards that currently apply to such policies in the private sector.

Other related concerns examined by the Congressional Research Service (CRS). Similar matters relating to the fairness and duplication of coverage for FEHBP enrollees with Medicare were recently examined by CRS in a report requested by the House Committee on Post Office and Civil Service.[22] The following issues were addressed.[23]

--*Medicare subsidization of FEHBP*. Because Medicare pays for much of their medical bills, FEHBP enrollees with Medicare argue that they are paying for duplicative protection--i.e., for coverage under FEHBP that they already get from Medicare--and that they and the Medicare program therefore are subsidizing other FEHBP participants.

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[21] Ibid.

[22] U.S. Congress. House. Committee on Post Office and Civil Service. *The Federal Employees Health Benefits Program. Possible Strategies for Reform*. Committee Print No. 101-5, 101 Cong., 1st Sess. Washington, U.S. Govt. Print. Off., May 24, 1989.

[23] Segments of the following discussion were taken directly from the CRS report.

Both CRS and OPM data show that FEHBP enrollees with Medicare cost FEHBP less than enrollees of the same age who are not covered by Medicare. The CRS report showed that for 1989, the estimated "pure premium"[24] averaged across all plans is $2,582 for all enrollees and $2,026 for enrollees with Medicare.

TABLE 5. FEHBP Plan Costs as Reflected in Pure Premiums[a] for Enrollees with and without Medicare, 1989

Type of coverage	Medicare enrollees	Nonmedicare enrollees	All enrollees
Single	$1,429	$1,612	$1,563
Family	$2,623	$3,302	$3,194
All enrollees	$2,026	$2,720	$2,582

[a] Premiums net of all administrative expenses and reserves. See footnote 24.

Source: Developed by CRS using OPM data.

The recent OPM study showed that FEHBP enrollees with Medicare incurred lower relative costs under FEHBP than other annuitant enrollees ages 55-65 and those age 65 and older not having Medicare.

TABLE 6. FEHBP Costs for Selected Groups of Enrollees Expressed in Relative Cost Factors, 1989

Type of coverage	Active employee	Annuitant (ages 55-65)	Medicare enrollee	Non Medicare (ages 65+)
Single	1.0	1.9	1.4	3.9
Family	1.0	1.4	0.9	2.6
Average	1.0	1.5	1.1	3.1

Source: OPM. Report on Offerring Medicare Supplemental Plans.

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[24] "Pure premium" is defined as the actual total premium charged by carriers (including both Government and employee contributions) net of all administrative expenses and reserve requirements. It is the amount of estimated claims (or benefits) paid by plans toward enrollee medical expenses, and thus represents the value (and the cost) of the plan's coverage.

However, the question of whether FEHBP enrollees with Medicare subsidize other FEHBP enrollees is not answered simply by data indicating that their cost to FEHBP is less than that of some other enrollees. Although they may feel that they have "paid for" their Medicare benefits separately, and question why Medicare benefits they receive should reduce the premiums of other FEHBP enrollees, in reality the value of their Medicare benefits far exceeds what they paid in Medicare taxes and premiums. This phenomenon is true for current Medicare enrollees generally but is even more pronounced for current Federal annuitants, because many have obtained Medicare eligibility through their spouses' covered employment or by being "grandfathered" into the system when Federal workers were covered in 1983. Thus, for argument's sake it would seem that the issue of whether enrollees with Medicare subsidize other FEHBP enrollees should take account of the inherent subsidy that they receive through the Medicare program, a subsidy provided in part by younger Federal workers currently contributing to Medicare.

As time passes, more and more Federal employees will work their entire career under Medicare (since Federal employment is now covered). Therefore, they will receive no more of a subsidy than the general population. Nevertheless, the argument that the Federal Government as the provider of both forms of insurance should integrate benefits under both programs, as private employers do, could still apply.

--Value of FEHBP for enrollees covered by Medicare. Another related issue is whether FEHBP enrollees with Medicare pay more in FEHBP premiums (i.e., what they actually pay out of pocket for their FEHBP insurance, and disregarding the Government contribution) than they receive in benefits from FEHBP? While the Medicare program pays for most (about 70 percent)[25] of their dually covered medical costs, FEHBP enrollees with Medicare pay no FEHBP deductibles and coinsurance, and generally have high medical expenses because of their age. Thus, their costs to FEHBP are still substantial even though Medicare pays much of their bills. The key question is whether the value of what are, in effect, *supplementary* benefits provided by FEHBP exceeds the premiums they pay.

The following table shows that the average pure premium value for FEHBP enrollees with Medicare is $2,026 while the average *actual premium paid* by enrollees with Medicare is only $1,079. The difference between the pure premium value and the actual cost to the enrollee (their share of the premium) is, of course, due almost entirely to the effect of the Government contribution (the Government's share of FEHBP costs). From this data, it would appear that, *in the aggregate*, FEHBP enrollees with Medicare receive more from FEHBP than they pay in premiums (with the Government picking up the difference in cost through its share of premium payments). Their aggregate benefits are almost double what they pay.

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[25] Derived from unpublished 1989 OPM data.

TABLE 7. Annual FEHBP Pure Premium Value Compared to Enrollee Share of Actual Premiums for Annuitants with Medicare, 1989

Type of coverage	Pure premium value[a]	Enrollee share of actual premium	Gain[b] on actual premium for Medicare enrollees
Single	$1,429	$ 807	77.2%
Family	2,623	1,352	94.0
All enrollees	$2,026	$1,079	87.7%

[a] "Pure premium" as discussed in footnote 24.

[b] Pure premium value that exceeds enrollee share of premium.

Source: Derived from OPM data.

–Potential overinsurance. Part of the perception of FEHBP enrollees with Medicare that they get a "bad deal" from FEHBP may be due to a tendency to overinsure themselves when choosing a FEHBP plan. Because OPM requires that FEHBP plans waive their coinsurance and deductibles for enrollees with Medicare, these enrollees have virtually 100 percent coverage of hospital and doctor expenses. Therefore, it is very advantageous for enrollees with Medicare to select plans with low premiums, while disregarding deductibles and coinsurance requirements (since they are waived). However, data show that many enrollees with Medicare select plans with high premiums, for which they receive little added protection.

In 1989, it is estimated that about 97,000 (12 percent) of FEHBP enrollees with Medicare are in the three most expensive plans.[26] They make up 36 percent of the total enrollees in these plans. Only 54,000 enrollees with Medicare are in HMOs, compared with 67,000 annuitants without Medicare and 279,000 active workers.

It is estimated that 48 percent of all annuitants in BC/BS High Option are entitled to Medicare (65 percent of those age 65 or over have Medicare). Fifty percent of all annuitants in Aetna High Option are entitled to Medicare (62 percent of those age 65 or over have Medicare). One might think that part of this phenomenon could be ascribed to the need to provide high coverage to a spouse not entitled to Medicare, but annuitants who elected Self Only coverage show the same pattern (49 percent of the Self Only in BC/BS

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[26] These plans have premiums at least 90 percent higher than the average of all FEHBP plans.

High Option are entitled to Medicare--and 63 percent of those age 65 and over).

Although the 1989 figures are not yet final, preliminary data from OPM show that in the latest open season BC/BS High Option lost 63,000 annuitants, a 19 percent reduction, while BC/BS Standard Option gained 81,000 annuitants. Almost 60,000 annuitants switched from High to Standard Option within BC/BS. Such data indicate that annuitants with Medicare as a group may have begun making more economical choices about their FEHBP coverage relative to their health insurance needs.[27]

--The impact of the Medicare catastrophic provisions on FEHBP enrollees versus private sector retirees. Basically, Medicare's new catastrophic health benefit provisions impact Federal annuitants in the same way as they do private sector retirees. However, there are a few differences.

In the Federal sector, the law requires that a rebate be given to FEHBP enrollees with Medicare, based on the amounts the new Medicare benefits are estimated to save the FEHBP plans. (As previously mentioned, in 1989 these expected savings have resulted in a $3.10-a-month rebate.) In the private sector, employers that provide retiree health benefits under plans that duplicate at least 50 percent of the new Medicare catastrophic benefits must provide the retirees with an equivalent amount of additional benefits under their plans or refund the amounts saved because of the Medicare duplication.

One difference between the two sectors, however, is that there is no expiration of the provision requiring OPM to provide FEHBP rebates for the duplicative coverage, while for private employers, the so-called "maintenance of effort" requirements (either to add benefits or to refund savings) apply only through 1989 with respect to Part A overlaps and only through 1990 for Part B overlaps. Further, these maintenance of effort provisions do not apply to benefits provided under collectively bargained multiemployer plans.

Another difference is in the way the new Medicare income-related premium (the surtax) is computed. Social security benefits are not taxable if the retiree's adjusted gross income (AGI) plus half the benefits are less than $25,000 ($32,000 for a couple), and thus social security benefits count in determining the new Medicare surtax only for higher-income retirees. When AGI plus half the benefits exceed the $25,000 and $32,000 thresholds, no more than half the social security benefits can be taxable (and thereby count in computing the surtax). Federal annuities, on the other hand, are largely taxable (usually 90 percent or more) without income thresholds, and therefore ordinarily would count in computing the surtax for virtually any Federal annuitant eligible for Part A of Medicare. Because it was perceived to be inequitable to charge Medicare enrollees with equal amounts of retirement incomes different supplemental premiums merely because of the way different kinds of retirement income are treated for income tax purposes, the new law includes an adjustment for retirees with governmental annuities. In 1989, 15 percent of $6,000 ($9,000 for a couple) of the Federal annuity (or the whole amount of the annuity if smaller) can be deducted from the enrollee's tax liability in the computation of the surtax. The $6,000 and $9,000 figures were explicitly set as a surrogate for the portion of the Federal annuity that is analogous to social security benefits (and therefore would be partially or fully exempt from taxation).

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[27] *Retirement Life*. May 1989. p. 16. Whether the switching from High to Standard Options was due to an overall increase in understanding by annuitants of their situation, or to the effect of the new Medicare catastrophic coverage, is unclear.

Using a rough measure of what portion of a Federal annuity might be viewed as a "substitute" for social security--40 percent for a worker with a "typical" Federal career--it would appear that the $6,000 exclusion ranges from being adequate to being too generous for Federal retirees with annuities under $15,000 or so in 1989. However, for those with annuities in the low $20,000 range and modest amounts of additional taxable income ($5,000-$10,000), the $6,000 exclusion may be too small and thus the surtax may be said to be too large. At higher income levels, the situation reverses itself again slightly, but overall the $6,000 exclusion appears to be adequate. Thus, because the exclusion rules are broad proxies for the influence of social security on the surtax computation, the actual effect of the supplemental premiums on Federal retirees can be different from that of retirees with similar income levels in the private sector.

MILITARY RETIREES

Military retirees become entitled to Medicare at age 65 since military service is covered by the program (since 1957). Military service, however, does not entitle an individual to FEHBP. A military retiree will not have FEHBP benefits unless the retiree or his or her spouse has become eligible from having worked in Federal civilian employment.

Military retirees may obtain health care services from a Department of Defense (DOD) facility, and if qualified, from a VA facility. As of the end of FY1988, approximately 435,000 military retirees over age 65, plus an unknown number of dependents, were entitled to receive services from DOD or VA facilities. The number of who actually received such services is unknown. Use of such facilities is contingent upon access to a facility and availability restrictions.[28]

MCCA made no changes in existing provisions relating to the military health services system. Those military retirees who have a sufficiently high income will be required to pay the new Medicare income-related premiums. Some of these individuals may continue to obtain health care (subject to availability restrictions) at a DOD or VA facility.

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[28] Military retirees under age 65 receive health care services through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA). CHAMPUS also covers the eligible dependents of active duty, retired, and deceased members of the uniformed services. CHAMPUS pays part of the costs of certain health care services furnished by civilian providers. CHAMPVA provides similar benefits for the eligible dependents of certain veterans. A CHAMPUS or CHAMPVA beneficiary loses entitlement to CHAMPUS or CHAMPVA if he or she qualifies for Medicare Part A.

PREPARED STATEMENT OF SENATOR DAVID L. BOREN

Mr. Chairman: I want to thank you for calling this hearing today to further discuss the Catastrophic Coverage Act. You have been most attentive to the concerns that we have heard from our constituents and from our colleagues about the program and you have acted promptly in calling these two hearings in the last six weeks.

I fully supported the Mitchell/Bentsen resolution in June calling for the Finance Committee to revisit several issues of particular concern. I voted for this resolution because I feel that it is the Committee's responsibility to respond to and address the problems that have developed over this legislation. In the June 1 hearing here in the Finance Committee, we reviewed the method of financing that President Reagan directed, that of requiring those who would benefit the program to pay for the program. This has come to be known as the "surtax." Since the collection of the 1989 supplemental premiums has begun, estimates suggest that there may be as much as a $9 billion surplus over the next 4 years. I support your efforts, Mr. Chairman, to reduce the premiums to the level needed to run the program. It was never intended to collect more money that needed from our senior citizens.

The second item of review, that of the possibility of making the program voluntary, is also of special interest to many of my constituents. When this measure originally passed the Senate in the 100th Congress, the program was voluntary, but was changed in conference with the House of Representatives. There are many Oklahomans who are Federal or military retirees, or who otherwise have company policies that offer duplicative benefits, who are especially concerned about this measure. Although the catastrophic act addressed this issue and requires employers to offer additional benefits or refund a portion of the premium, this is an item that continues to be debated and deserves to be the focus of this hearing.

Again, Mr. Chairman, thank you for calling for this hearing today to explore the possibility of these changes.

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

Mr. Chairman, I applaud you for holding these hearings. Today we are to focus on two issues that have been at the center of the controversy over the new catastrophic benefits: the duplication of coverage and the mandatory nature of the coverage.

I, for one, have always believed that the new catastrophic coverage should be voluntary. I have joined with Senator Baucus in sponsoring a bill which would do this by tying the coverage to Part B. Making catastrophic voluntary—as it was in the original Senate-passed bill—has the potential to address most of the complaints that have been levied against the new benefits. Seniors will have the opportunity to review the coverage, compare it to what they may already have through an employer or private policy, and make a decision. Those who want it will have that option. Those who don't can opt out by opting out of Part B.

I still believe that the Catastrophic Coverage Act offers a package of good, solid benefits that provide real protection against catastrophic expenses. 56 percent of all Medicare beneficiaries will get this catastrophic coverage for only $48 per year in addition to their usual Part B premium. Another 28 percent will get it for less than $350 dollars per year. This is a real bargain when you consider that Medigap policies—many of which do not include the catastrophic benefits that people actually need most—can cost anywhere from $600 to $1500 per year.

And even those who will pay the maximum supplemental premium—which amounts to only 6 percent of all Medicare beneficiaries still receive a sizable subsidy on their total Medicare benefits: $800 per year even for the *least*-subsidized group, according to CBO. As good a value as it is, however—people should have the opportunity to make that choice for themselves.

As for duplicated coverage, making the program optional will also address many of these concerns as well. We should also make adjustments that will allow the catastrophic benefits mesh better with plans from private employers and the Federal Government.

The real duplication problem, as I see it, lies with private Medigap plans. Not that the Medicare catastrophic benefits duplicate Medigap plans—we specifically prohibited that in the law and need to make sure the prohibition is enforced. The real problem is the duplication *among private Medigap plans.* As many as a third of senior citizens own two or more Medigap policies—some own as many as a half dozen plans that are virtually identical. In response to high-pressure sales tactics that prey upon their fears, the elderly are overinsuring themselves with policies that often are of dubious value. There is good reason to be concerned that states are not being aggressive enough in regulating the plans, with result that abuses in the private Medicare market persist despite the regulations we enacted in 1980.

The long and short of it is this: no matter how much we do to eliminate overlap between Medicare catastrophic and other plans, the duplication among private Medigap policies will still exist unless we take action on that front as well. This is an area where the elderly are spending, in some cases, thousands of dollars per year on coverage that is completely superfluous. Directing our attention to these abuses would be time well spent, in my opinion, and would be a real benefit to senior citizens.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR DAN COATS

Mr. Chairman, I would like to thank you for the opportunity to present my views on the Medicare Catastrophic Coverage Act (MCCA).

It is clear that the MCCA must be re-examined based on the information that has come to light since the law was passed last year. The estimates of program costs, the problem of duplication for people forced to pay the surcharge, and the views of the group who the law is intended to help combine to make it timely for this Committee, and Congress as a whole, to look at the goals we envisioned when this law was being shaped.

The latest numbers from the Congressional Budget Office (CBO) show a disturbing drop in the MCCA's projected contingency margin, especially in the drug insurance trust fund. I am not aware of one Medicare program that has come close to meeting projected costs since this system was launched in 1965. The overruns are legendary. Common sense tells me that when the planned margins for the MCCA begin to drop so sharply in just one year, there is little hope that the program will not be severely in the red by 1993. The hard reality of the budget deficit makes it clear that budget neutrality is a basic requirement that Congress cannot ignore in dealing with the MCCA, and the present scheme makes that most unlikely.

Another factor that must not be overlooked is the large number of seniors who have duplicate coverage with the MCCA and are being forced to pay the supplemental premium. According to the Congressional Research Service (CRS) of the Library of Congress, an astonishing 29% of the non-institutionalized Medicare beneficiaries have at least some health insurance coverage from an employer. There is another sizable group that works and receives health insurance as a fringe benefit. Although these seniors are fortunate to have medical benefits, they are still hard pressed to pay an additional tax for coverage they do not need. It would be far better to restructure MCCA to cover basic acute care needs, eliminate the supplemental premium and let the seniors choose whether they want it.

Finally, since one of the basic tenets of the law is that it be beneficiary financed, it is important that the MCCA have the support of a goodly portion of the seniors. As we all know, a substantial portion of the elderly oppose it. According to a Wirthlin Group poll that was conducted in May of this year, the 59% of the seniors who were aware of the program opposed it by a margin of 53%-31%. Even those who favored the program believed the benefits were not worth the costs. Those of us who serve in this body do not need a poll to know how the seniors feel. I have received almost 9,000 pieces of mail about the MCCA, and the overwhelming majority do not like this law.

It is not reasonable to expect a consensus on a law as complex as the MCCA, however, the discontent in Indiana is not the result of a clever mass mail campaign by a narrowly focused group. Every senior I meet in town meetings, or any other meeting, make it a point to tell me how much they dislike this law. I believe that the MCCA should be beneficiary financed, however the cost should be cut and the benefits realigned so that seniors will have good reason to conclude that the whole package is a good deal and worth supporting.

Mr. Chairman, I know you are well aware of the questions that have been raised about the MCCA, and I would like to commend you for holding this hearing so that these problems can be addressed. I believe seniors deserve an acute care program that will meet their basic needs at a cost that they can afford. As I explained above, this program should be budget neutral, beneficiary financed, and redrawn to cover basic acute care needs so that it would be actuarially sound to make it voluntary. As you know, I have introduced S. 1174, a bill that I believe abides by these principles. I urge you and this committee to give it your most serious consideration as the debate on the MCCA continues.

Your leadership will be critical to saving the worthwhile idea of acute catastrophic care for the elderly, and I look forward to working with you to meet this challenge.

PREPARED STATEMENT OF SENATOR BOB DOLE

Participation in the Medicare Program should not be viewed as a burden, but that in fact is the situation we have created. The new benefits that were added by the catastrophic bill are a mixed blessing. The problems we are faced with are both those related to the apparent duplication of coverage being experienced by some and the size of the premium being faced by others. Senator McCain and others have done an excellent job of alerting us to these real problems.

With respect to the duplication of coverage being experienced by some, there is no question that the problem is real. An attempt was made to address some of these concerns at the time of passage of the bill but more may well be necessary. Military retirees in particular have a legitimate complaint. Federal employees also deserve our attention as changes in FEHBP were certainly anticipated but have not yet occurred.

The witnesses before us today will no doubt have different views as to what the problem is and what the solutions should be. But the solution is not in the view of this senator simply a question of replacing the supplemental premium with general revenues.

However, at a minimum we should return to the position taken by the Senate at the time of passage of the bill and link participation to Part B so it is voluntary. If in fact the benefits are as good as many argue they are, then people will choose to be covered. In my view people have the right to make a choice.

With respect to the bigger issue of the size and structure of the premium, the jury is still out. If in fact a surplus truly exists adjustments should be made.

However, if we find that we do not have a surplus, and there is still dissatisfaction with the program perhaps the next step should be to review the benefits themselves. I for one believe that we may have taken on more than was necessary and that we could handle. The respite benefit and the drug benefit are among those that may warrant careful review.

I am looking forward to the testimony of those here today as it will hopefully assist us in making appropriate adjustments in the program.

PREPARED STATEMENT OF CONGRESSMAN HARRIS W. FAWELL

Chairman Bentsen, thank you for giving me the opportunity to testify before you on the issue paramount to most senior citizens in the United States today, the Medicare Catastrophic Coverage Act of 1988.

Joan Beck, syndicated columnist with the Chicago Tribune recently stated: "Thousands of senior citizens have tried very hard to change the Medicare Catastrophic Care Act—in all the civics textbook ways. They have written bags full of letters to members of Congress. They have formed coalitions, lobbied, held meetings. They have had surveys and polls taken. They have persuaded sympathetic members of Congress to introduce bills to repeal or postpone or amend the law—and watched the proposals molder in committees, it they get that far."

Your consenting to having this hearing today to review the financing portion of the bill and the voluntary aspect of the law is commendable.

A review of this type, while commendable, is not sufficient. I still believe the only way to right the wrong of passing Public Law 100-360 is to repeal the whole thing. Congress made a mistake and now Congress owes it to the citizens it serves to correct that error.

We passed a law outlining benefits for a group of people without considering what that group of people wanted in a benefit program. We then demanded, through a mandatory surtax, for those same people to pay for those benefits even if they never took advantage of them. Finally, we even went so far as to craft this surtax so that it mandates subsidizing of another group of people, those seniors who pay no income tax. This special tax on a special group of people to subsidize yet another group has never been done before, and now we know why.

The House Republican Research Committee Task Force on the Medicare Catastrophic Care Act recently came to a consensus to support the proposal put forth by Senator McCain, with a minor adjustment. I introduced, H.R. 2770, June 28, 1989. It provides for a one year delay of all Part B benefits, the drug benefit, and the supplementary premium. It retains on schedule, the extended hospital and skilled nursing home care provisions as well as the three Medicaid provisions included in Public Law 100-360.

We feel that for Congress to do justice to this issue and really respond to the seniors' concerns, we need at least a year to fully review each benefit of the current law and determine whether or not this is the expansion of Medicare seniors want in order to meet their catastrophic health care needs and how such needs can be equitably funded.

Senator Bentsen you have stated your support for a reduction in the supplemental premium. I do not advocate such a move for several reasons. First, changing estimates of income tax revenues to finance the Catastrophic Care Act does nothing to correct the fatal flaws of this legislation which expands Medicare in the wrong direction. Second, the supplemental premium, even if reduced (probably only temporarily) is still an open-ended age discriminatory special income tax, primarily weighted upon middle-income seniors. Since it is a "tax upon a tax," it is a permanent "double hit" against seniors every time there is a change in the definition of taxable income or a change in income tax rates. Thirdly, Congressional cost estimates of the Medicare program have been notoriously underestimated. For instance, the projected costs of the Medicare program for 1990, made in 1965, was $8.8 billion. We all know it will be in excess of $100 billion! Considering the current disputed estimates between CBO and HCFA, I believe it would be imprudent to tamper with estimates of financing this Act.

The Finance Committee has also circulated the idea of making the benefits of this Act voluntary. As I understand it, however, a person could opt out of catastrophic coverage only if he or she also opted out of Part B.

We all know that seniors have supported and built their retirement years around Part B since it was first offered. Few could sacrifice that coverage in order to opt out of the catastrophic package.

If you posed the option of a TRULY voluntary catastrophic package to seniors, the vast majority of middle income seniors would not take it. The Congressional Budget Office knows this and seniors know this. So what you are doing is making an offer that you know people cannot accept.

Only a straight repeal or at the very least, a real review, through a one year delay as suggested by Senator McCain, will allow us to get to the heart of the matter.

The letters senior citizens have written Joan Beck best summarizes their feelings: "Their letters call the Medicare Catastrophic Coverage Act a hoax, a sham, a rip-off, a catastrophe itself, a nightmare, a clever ploy to soak retirees and shave the deficit, a sick joke, a swindle, 'elderly bashing,' and in the words of a veteran from Bessemer, Alabama, "a financial Pearl Harbor sneak attack."

Prepared Statement of Arthur S. Flemming

DUPLICATION OF COVERAGE

I. Introduction

A. Save Our Security (SOS) is a coalition of over 100 national, state and local, aging, and disability groups. Founded in 1979, by the late Wilbur I. Cohen, SOS supports a strong Social Security and health care system in America.

B. There has been widespread national concern over the financing of the Medicare Catastrophic Protection Act of 1988, P.L. 100-360.

1. The SOS Coalition supports all the new benefits incorporated in this Act.
2. Member organizations of the SOS Coalition share, however, a common concern over the inequities that are built into the coordination provisions in the Medicare Catastrophic Protection Act of 1988
3. They do not believe that any beneficiaries should be placed in a position where they are called upon to pay twice for essentially the same benefits.
4. This situation confronts State and local retirees, Federal retirees, and many retirees who have health benefits under employer-sponsored retiree health plans as well as retirees who receive catastrophic benefits under HMOs.

C. As a partial response to the duplicative payment issue there was included in the Medicare Catastrophic Protection Act a maintenance of effort provision which requires any employer (including state and local governments) that was previously providing to their retirees 50 percent or more of the benefits included under the Medicare catastrophic program (including prescription drugs) to provide either additional benefits or a cash rebate to the retirees equal to the value of the duplicative health benefits. This obligation only applies for one year with respect to improvements under Medicare Part A, and one year with respect to the improvements under Part B, or until the end of an existing collective bargaining agreement (if later).

II. Body

A. The SOS recognizes that the duplicative payment issue could be alleviated by amending the maintenance-of-effort provision so as, for example, to provide for:

—making it permanent for persons who have already retired applying it to all individuals covered under employer-sponsored retiree health plans which provide duplicative coverage and not simply individuals who retired prior to the date the Medicare catastrophic program was enacted

—applying it to all of the benefits provided under an employer-sponsored health plan which duplicates any of the benefits provided under the Medicare Catastrophic Protection Act.

—lowering the threshold for applying the maintenance-of-effort obligation so that it applies to any employer which previously provided 25 percent or more of the benefits added under the Medicare catastrophic program.

1. Such steps would alleviate but not meet head-on the duplicative payment issue.

2. We believe that there is an additional step, however, that could be taken that would really clear the air.

B. We believe that the law should be amended to allow employers (including State and local governments) in lieu of the maintenance of effort obligation, to make payments to Medicare on behalf of all retirees in lieu of their making the supplemental payments themselves equal to the annual actuarial value of the catastrophic program for which they are now paying minus the amount of the flat premium in that year. If a payment based on the actuarial value leads to a revenue shortfall then the payment by the employer could be equal to the amount the beneficiary would have paid.

1. The companies should still be required to make a rebate to each retiree (or add additional benefits) equal to the value of the flat premium.

2. The existing Catastrophic Health Insurance law forces only the retirees who are involved in the duplicative issue to pay increased out-of-pocket costs.

a. Employers will be realizing substantial savings.

b. The extent of the decrease in employer expenditures is documented in the June 14, 1989 testimony before the Ways and Means Subcommittee on Oversight by Lawrence H. Thompson, Assistant Comptroller General, Human Resources Division of the General Accounting Office: Medicare Catastrophic insurance will reduce companies' costs for retirees age 65 and over by 5 percent in 1989, by 15 percent in 1990, and by 19 percent when fully phased in . . . . After incorporating savings from the Medicare catastrophic legislation, our estimate of companies' accrued retiree health liabilities falls to $197 billion, a 13 percent decrease. If the nation's employers had started advance-funding these accrued liabilities in 1988, their first-year funding costs would have been $28 billion. This is about 3 times their 1988 pay-as-you-go costs.

c. In brief, under existing law the employer's financial burdens are reduced and the retiree's burdens are increased.

3. Under the Buy-In proposal—

—On balance the employer community would not be paying more over any given period of time than they otherwise would pay for these benefits as they would in effect simply be making a change in insurance carriers.

—Also the Government would not suffer a revenue loss because the revenue obtained by the employers' purchase of catastrophic benefits from Medicare would offset the loss of surcharge revenues.

—Duplicative payments for catastrophic benefits would be eliminated.

C. If a decision is made to permit employers (including State and local governments) to purchase catastrophic benefits from Medicare we recommend that the following additional steps be authorized:

1. Permit employers who are not currently paying for catastrophic benefits for retirees to purchase these benefits from Medicare in lieu of the retirees making the supplemental payments themselves.

2. Authorize the Federal Government, as an employer, to make payments to Medicare on behalf of all Federal retirees for the catastrophic benefits in lieu of the retirees making the supplemental payments themselves.

3. Similarly, authorize Health Maintenance Organizations (HMOs) to purchase catastrophic benefits from Medicare in lieu of their Medicare beneficiaries making the supplemental payments themselves.

III. CONCLUSION

A. We recognize that this proposal does not deal with the fundamental issue, namely, that improvements in Medicare should be financed by the entire ',community1, and not just by beneficiaries.

B. It would, however, deal with an inequitable situation—a situation which if it is not corrected will undermine confidence in the Federal Government's commitment to fairness.

PROPOSALS TO MAKE MEDICARE CATASTROPHIC PROGRAM "VOLUNTARY"

I. Introduction

A. Two proposals have been advanced to make the Medicare catastrophic program "voluntary."

1. One proposal would allow retirees to decide to drop out of the catastrophic program but continue to be covered by the Medicare Part B program.

2. Another proposal would allow retirees to drop out of the catastrophic program only if they also decided to drop out of the Medicare Part B program.

B. Either one of these proposals would start the nation down the slippery slope of seriously weakening one of the basic concepts incorporated in our Social Security program, namely, the concept of compulsory and therefore virtual universal coverage.

II Body

A. The concept of compulsory coverage has brought some genuine benefits to our nation.

1. Because Social Security covers virtually all employment a very high percentage of our working population build their eligibility and credits wherever they work which in turn provides them with an added incentive to move whenever such a move is in their best interest and oftentimes when it is in the nation's interest.

2. The success to date in resisting efforts to dilute the concept of compulsory or universal coverage by permitting individuals to voluntarily leave all or parts of the Social Security System has helped to keep the System on a sound financial basis by protecting it against adverse selection.

a. Anytime persons are given the right to withdraw voluntarily from any part of the System, the System runs a genuine risk of losing far more of the "good" than the "bad" risks.

b. If this happens the System will have to obtain additional revenues to replace its loss of revenue from "good" risks in order to meet its commitments to the "bad" risks.

c. In addition some of the "good" risks that leave will discover that they made the wrong choice and, as a result, the nation may find it necessary to provide them with support through the welfare system.

3. There is no doubt that the adoption of either one of these proposals for voluntary withdrawal from the Medicare Catastrophic plan would lead to adverse selection.

a. It is clear that the adverse selection would be greater if the beneficiary is not required to also withdraw from Part B.

b. Adverse selection would also be greater if the issue of duplication of payments for catastrophic coverage is not dealt with in an adequate manner.

B. Even a small step down the slope of a "voluntary" approach to Social Security of compulsory or universal coverage—which some may allege these proposals to be—is almost sure to encourage other exceptions with a resulting serious weakening of the concept.

III. Conclusion

A. Whenever we narrow the definition of the "community" participating in any aspect of our Social Security System we will pay a price—the price of weakening the System.

B. Dr. Rashi Fein, one of the nation's leading authorities in the field of health care, says "We paid a price, I fear a heavy price, when we redefined "community" and opted for a financing system in which the group at risk is supposed to finance its own services."

C. We would pay a price—a heavy price—if we redefined "community" by retreating from the concept of universality by authorizing "voluntary" withdrawals.

SAVE OUR SECURITY (SOS)
July 12, 1989.

Hon. LLOYD D. BENTSEN,
U.S. Senate,
Washington, DC.

Dear Senator Bentsen: I appreciate very much your providing me with the opportunity of testifying before you and members of your committee on the Medicare Catastrophic Protection Act.

If your time had permitted in the question and answer period would have—

—underlined our opposition to proposals for postponing the effective date of the Act.

—stated our opposition to solving the financing problem by eliminating the prescription drug benefit.

—associated myself with Senator Pryor's efforts as Chairman of the Select Committee on Aging to endeavor to identify the causes for the projected sharp increases in drug prices.

I would appreciate it if this letter could be made a part of the record of the hearing.

Again, thank you so much for the time and thought you are giving to health care—an issue which belongs close to if not at the top of our nation's domestic agenda.

Sincerely,

ARTHUR S. FLEMMING, CO-CHAIR.

PREPARED STATEMENT OF LINDA JENCKES

Mr. chairman and members of the committee, I am Linda Jenckes, Vice President of Federal Affairs for the Health Insurance Association of America. HIAA is a trade association representing some 350 insurance companies who write approximately 40 percent of the health insurance in this country. While 60 member companies underwrite private Medicare supplement policies, the top ten carriers write the lions share of this business.

I'd like to begin by saying that we empathize with you. Members of congress aren't the only ones having to explain to confused senior citizens the changes in their benefits, premiums. and taxes that have come as a result of the catastrophic legislation. The HIAA, its member companies, and their agents are also being inundated with calls from reporters, consumer groups and policy holders seeking information and explanations. I'm not sure anyone quite expected this degree of beneficiary disquiet.

The fact is, industry representatives spent a good deal of time during the consideration of the catastrophic bill working with congressional committees to assure a smooth transition for the 70 percent of Medicare beneficiaries who also have private insurance to supplement Medicare. The HIAA also worked with the National Association of Insurance Commissioners and state insurance department officials to guarantee continuity of coverage for policy holders during this confusing period.

As the fruit of these efforts, the catastrophic bill included clear provisions requiring that all Medicare supplemental policies be amended to eliminate any duplication with the expanded Medicare benefits by January 1, 1989. As each state of the catastrophic benefits are phased in over the next three years, private insurers must: (1) inform policy holders of the changes, (2) issue policy riders eliminating duplicate coverage, and (3) commence rate adjustment proceedings with the state insurance departments in order to guarantee that policy holders get appropriate premium adjustment for the amended coverage. These steps are required for all Medicare supplemental policies in force. Beneficiaries with employer provided health insurance to supplement Medicare are getting cash rebates or new benefits as required by the "maintenance of effort" provision of the Catastrophic Act.

To my knowledge, all of the provisions in the catastrophic legislation which set out the steps to be taken by state insurance regulatory officials to assure a swift and efficient transition have occurred as planned and with little contention. The National Association of Insurance Commissioners has met all of the deadlines for amending its model regulations for Medicare supplemental policies.

States are now in the process of adopting the appropriate statutory and regulatory changes necessary to conform with Congress' expectations. It is also my understanding that the overall goals of Congress in adopting and subsequently enhancing the 1980 Baucus amendments (P.L. 96-265) which establish the framework for Federal standards and state regulation of Medicare supplemental policies, are being fulfilled. That has been the testimony of the General Accounting Office and the Health Care Financing Administration as stated in reports to Congress.

Let me describe the pattern of private health insurance coverage sold to the Medicare population.

Nearly all elderly Americans participate in the Medicare program. Less understood is the extent that the elderly are covered by other health insurance policies. Data from the Bureau of the Census indicate that approximately 71.5 percent of the 30 million elderly are covered by private health insurance, and another 11 percent have Medicaid coverage.

Although 90 percent of the elderly are no longer actively engaged in the work force, employer-sponsored health insurance still plays a major role for many elderly in protecting them against the cost of health care. Date from the Employee Benefit Research Institute indicates that about one of every four elderly citizens 7.6 million individuals—have employer-sponsored health retirement benefits. A recent survey of 500 elderly conducted by HIAA and Response Analysis would place that figure at over 30 percent.

Another HIAA survey found that employers pay an average of 85 percent of the cost for single coverage, and 77 percent for family coverage. Thus, a typical single retiree will pay $15 per month while a family retiree pays $48 per month. Employers also pay the full cost of Part B Medicare premiums for over 40 percent of their retirees, and 34 percent of their spouses. Employer-sponsored health plans are essentially continuations of active employee coverage. Nearly 75% of these plans are "Medicare carve out plans" where the employer calculates the benefits payable under the plan and reduces the payments by what Medicare pays.

Benefits in retirement plans are broad; for example, 94 percent of retirees are covered for prescription drugs and 91 percent have home health coverage. Nearly 90 percent have catastrophic thresholds after which the beneficiary is no longer responsible for co-payments.

Our surveys also show that over 80 percent of the elderly remain satisfied with both the costs and benefits of their private coverage. Over 80 percent of owners of private policies plan to retain their current policies, three percent plan to drop them, and 15 percent don't know.

I would also like to comment on the fact that your attention is occasionally drawn to the marketing of insurance to the elderly. While numerous Congressional hearing have shown that the problems addressed by the Baucus Act in 1982 still crop up, there are procedures in place to find, prosecute, and eradicate the improper and illegal activities of those unscrupulous agents and companies who would take advantage of the elderly. Since one of the primary functions of the state insurance departments is to protect the consumer from marketing abuse, we think it appropriate that the occasional abuse that are reported to be dealt with at that level. Let me assure you, Mr. Chairman, that the HIAA will continue to press for changes in state insurance regulations that will help weed out "bad apples" and promote increased consumer protection. We are presently working with Representative Dingell (D-Mich) chairman of the House Energy and Commerce Committee, as well as the NAIC to develop a proposal which would eliminate duplication of Medicare supplemental policies. We would be happy to provide you with this proposal if you would like to consider it.

In our opinion, this is not an area where Congress needs to add more statutes to the law books. In addition to broad authority to regulate insurance, virtually every state has in effect the Unfair Method of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance statute. All 50 states have enacted legislation that is equal to NAIC Medicare Supplement Minimum Standards Model Act. The text of the Unfair Trade Practices Act is lengthy; it addresses virtually every aspect of company and agent activity and prohibits practices such as providing false information or advertising, rebates, unfair discrimination, unfair claim settlement practices and other unfair methods of competition or deceptive acts or practices.

Insurance departments have other sanction authority such as the agent licensing laws which also enable the state to issue fines, revoke licenses and publicize the results of disciplinary actions. While we have enough laws; how to improve their enforcement remains a valid question. The National Association of Insurance Commissioners is addressing this very issue in a hearing scheduled for July 21 here in Washington. The Commissioners have a number of consumer protection measures under consideration. They should be given a change to conclude their deliberations.

I would now like to discuss the role that professional health insurance agents play in selling and serving Medicare supplemental policies, and the use of Medicare supplemental policy loss ratios as a measure of the policy's value to consumers.

Because licensed agents help bring health insurance to millions of individuals young and old, their important role should not be misunderstood or underestimated. Agents can perform all of the following services for the elderly: explain Medicare's benefits, describe how policies will pay benefits, hand deliver policies and review options; answer questions; assist in claims filings, and help schedule medical Provider reviews.

Seniors who are members of a group or association which offers access to a group Medicare supplement policy, as some 40 percent of beneficiaries are, probably buy through the mail, and never see an agent. However, about 25 percent of beneficiaries chose to purchase individual Medicare supplemental policies through a professional health insurance agent in the neighborhood.

The fact that approximately 8 million seniors turn to agents for advice on their health insurance needs is testimony to the value of the service they offer. Understanding the Medicare program and its benefits can be difficult and confusing. Beneficiaries in need of advice can call the regional Social Security office, the local Medicare carrier or intermediary and the area senior's consumer hotline. Or, they can rely on their local licensed professional health insurance agent, or call one from the yellow pages. In the vast majority of cases, the elderly turn to the agent who has the training, time and answers to best help them.

In recognition of the importance of the service that agents provide, the Federal and state minimum standards for individually sold Medicare supplemental policies require a 60 (65 percent in some states) loss ratio rather than the 75 percent loss ratio for group policies including the AARP's products.

While direct mail and associations can be used to sell basic policies which meet the Federal minimum standards, companies have found that many people want a trained agent to explain Medicare benefits and the need for supplemental coverage, including long-term care.

Isolated cases of marketing abuse are inherently difficult to eradicate. We in industry remain committed to doing all that is reasonable to eliminate the problems. I am none-the-less confident that all those seniors who purchase or maintain Medicare supplemental policies year after year find good value in these products and in the service provided by the professional health insurance agents who advice them.

Why are Medicare supplemental premiums increasing? There are several reasons why premiums for Medicare supplement policies have increased in 1989, despite the enactment of the Catastrophic Coverage Act.

First, some aspects of the Catastrophic Act which have had a favorable impact on private supplemental insurance premiums. According to actuaries at the Health Care Financing Administration, the full actuarial value of the new catastrophic hospital and skilled nursing facility benefits which went into effect on January 1, 1989, is $65/year per beneficiary. We estimate that this factor all alone represents a benefit reduction of 8-12 percent in the average Medicare supplement policy.

There are, on the other hand, a number of premium increasing factors that more than offset this reduction.

(1) The Medicare Part A deductible was increased from $540 to $560 in 1989. Based on past experience, we expect approximately one-quarter of the 32 million Medicare beneficiaries to enter a hospital at least one in this calendar year. Since most Medicare supplement policies cover the $560 hospital deductible, this represents an increase of raw claims cost of approximately five dollars per beneficiary. The impact on premiums for the average policy will be an increase of approximately 1.5 percent.

(2) Effectively January of 1989, Congress approved a three percent increase in the prevailing charges paid to participating physicians for primary care services (e.g., office visits, emergency department services and skilled nursing care). The prevailing charges for other Medicare covered services for participating physicians will increase one percent. Since Medicare supplemental policies pay the 20 percent of Med-

icare allowable charges for which beneficiaries are liable, increases in prevailing charges automatically increase the cost of private policies by an amount identical to the percentage increase in Medicare's payments to Part B providers.

(3) Despite experiencing normal increases in claims costs, many companies report that premium increases were deferred in 1988 until it became clear what type of catastrophic legislation Congress would adopt. Once the legislation was passed in mid 1988, companies began to plan for the cost implications of the benefit adjustments associated with the Catastrophic Act requirements and therefore made up for the deferral of premium increases in 1988. The net effect of waiting was to increase the premiums needed in 1989.

(4) When one looks at the causes for the largest reported premium increases, you will probably find that the insurer involved has started to use *area specific rating.* Many of the largest Medicare supplemental writers, including the AARP/Prudential, Blue Cross and Blue Shield Plans and other commercial insurers formerly charged a single rate for each of their standard supplement policies. This year, however, many companies have moved to regional rating, i.e., charging higher premiums in those areas of the country where medical care charges are the highest. While this has resulted in smaller or no premium increases for beneficiaries in areas where Medicare costs are low, some surprisingly high increases have occurred in high cost urban areas.

(5) Each of the aforementioned factors contribute to rising premiums, but even when combined, they still are no match for *rising medical care costs.* Since the majority of the claims liability for Medicare supplemental insurers stem from the twenty percent of Medicare approved Part B charges which are left for beneficiaries to pay, this line of business is subject to all of the same forces that drive up Medicare Part B costs.

Insurers across the nation have noticed a significant upward swing in the volume of physician and out-patient claims. So has Medicare. Because of rising physician fees, greater volume of services provided the elderly, and coverage for the new technologies which make it possible to do procedures in other than the hospital setting, Medicare Part B payments have doubled in only five years from $13 billion in 1983 to $28 billion in 1988. That's a compounded rate of 16 percent per year.

Like Medicare Part B, Medicare supplement companies are seeing huge increases in the volume of claims they receive. We suspect this is due in part to providers "debundling" of services. Debundling, or increasing the volume of covered services per beneficiary, is one way providers can compensate for recent Federal restrictions and cutbacks in provider payments. Medicare and Medicare supplemental insurers are defenseless against this form of provider cost shifting.

We also feel the effect of the incentives built into the Medicare prospective payment system which encourages a shift away from impatient hospital treatment more to outpatient procedures. Outpatient procedures are covered primarily by Part B and at 80 percent of Medicare's allowable fee versus 100 percent when done on hospitalized patients. This also means that Medicare supplemental policies must reimburse 20 percent of a sharply increasing number of outpatient claims.

I wish to stress that Medicare supplemental premiums are increasing because companies are seeing increases in both the cost and volume of medical claims which exceed savings from the Catastrophic Coverage Act. Annual increases in claims costs per beneficiary in the order of 16-18 percent are common. While there are a large array of factors which caused claims costs to increase at this level each year, cost increases for Medicare supplemental policies closely parallel increasing Part B costs to Medicare. Only drastic nationwide solutions can effectively cope with skyrocketing expenditures for physician services.

CONCLUSION

While the HIAA tried to convince the Congress that long-term care needs of the elderly should be a higher priority for Congress than expanded Medicare coverage for hospital and doctors services, the industry has adjusted to the will of Congress and is amending its benefits accordingly. We do hope, however, that you see the wisdom of directing whatever future Federal health resources may become available for the elderly, into tax incentives that will accelerate a developing market for private long-term care policies (which a favorable tax incentive would offer). They also feel that the government's role should be limited to providing care for the poor and near-poor.

Attachments.

THE ELDERLY AND THEIR HEALTH CARE COVERAGE

(Prepared by: Thomas Rice, Ph.D. and Katherine Desmond, submitted to: Health Insurance Association of America)

INTRODUCTION

The purpose of this document is to report on findings from a national survey of Medicare beneficiaries, conducted in April and May of 1989. The survey, sponsored by the Health Insurance Association of America (HIAA), was designed to address a number of important questions concerning Medicare coverage and private supplemental insurance policies owned by the elderly. These included:

- How much do the elderly know about the recent changes in Medicare that came about as a result of the Medicare Catastrophic Coverage Act?
- How concerned are they about the remaining gaps in Medicare?
- How satisfied are they with the changes in Medicare brought about by the recent legislation?
- What types of private health insurance policies do they have and how did they purchase them?
- How satisfied are they with their private insurance policies?
- Do they plan to drop their private insurance as a result of the legislation?
- If they are briefed about the new legislation's benefits, do they respond any differently?

BACKGROUND

Political Context

Last year, Congress made some substantial changes in the Medicare program—the first major changes in the benefit and financing packages that beneficiaries have seen in the nearly 25 years since the program was enacted. Rather than rejoicing, however, there has been a great deal of public opposition to the Medicare Catastrophic Coverage Act among the elderly, centered largely on its financing methods, but also on what some consider to be its shortcomings in protecting the elderly from catastrophic health care expenses.

There are now a number of proposals before Congress to revamp the legislation. These include making the additional benefits and payments (monthly premiums and additional income taxes) voluntary, lowering maximum income tax liabilities, spreading the cost of program benefits beyond the elderly, and even scrapping the new benefits in their entirety. It is difficult for Congress to act, however, since it is unclear whether the public opposition is that of a vocal (and relatively wealthy) minority or, alternatively, is broad-based.

Beyond the issue of the legislation's popularity, another issue of concern is what spillover effects, if any, will be felt in the private insurance market. Over 70% of Medicare beneficiaries own private health insurance to supplement Medicare,[1] an estimated $13 billion market in 1986.[2] A question raised by the legislation is whether beneficiaries will now drop their private health insurance coverage because they believe Medicare's new benefits will provide sufficient protection.

The Medicare Catastrophic Coverage Act

The Medicare Catastrophic Coverage Act (MCCA), enacted by Congress in 1988, makes a number of changes in both program benefits and financing that will be phased in over the next several years. The three most important new benefits involve hospital care, Part B expenses (primarily, physician care), and prescription drugs. Beginning in 1989, beneficiaries are no longer responsible for substantial daily copayments for hospital stays in excess of 60 days, and furthermore, they must pay the $60 initial deductible only once in a single calendar year. Starting in 1990, there will be a $1,370 annual cap placed on Part B copayments. Prescription drug coverage—an entirely new Medicare benefit—will be phased in between 1991 and 1993; ultimately, Medicare will pay 80% of drug costs after an annual deductible of approximately $600 is met.

There are a number of other benefit enhancements as well, most notably liberalization of Medicaid regulations in order to allow the spouse of a nursing home resident to retain enough income to avoid impoverishment. Although there were some modest changes in the Medicare nursing home benefit, one of the primary complaints about the legislation is that it does not extend Medicare coverage to long-term nursing home care. This is the type of care that is most likely to impoverish the elderly.[3]

Unlike prior Medicare benefits, the new ones are to be financed entirely by program beneficiaries. Most of the cost will be funded through the controversial "supplemental premium," which is actually an additional amount of income tax to be paid by an estimated 40% of the elderly. The maximum tax liability, which will be paid by less than ten percent of the elderly, is scheduled to be $800 per person ($1,600 for a couple). In addition to the supplemental premium, the Part B monthly premium charged to all program beneficiaries whose incomes are above the poverty level will rise by four dollars.

After the benefits are fully phased in, the following expenses will still be borne by beneficiaries (or by their private insurance policies): the initial $560 hospital deductible; the $75 Part B deductible and 20% coinsurance payment until annual expenses of $1,370 are incurred; all non-assigned physician charges above what Medicare deems to be reasonable; the first $600 of prescription drug costs; and 20% of all additional prescription drug costs during a year.

THE SURVEY OF MEDICARE BENEFICIARIES

To address the research questions posed above, a telephone survey of 500 Medicare beneficiaries was conducted in April and May of 1989. The survey, carried out by Response Analysis, Inc. in Princeton, New Jersey, was based on a nationally representative sample chosen using random-digit dialing.

In conducting the survey, it was found that only a small fraction of those households contacted were eligible, because only those households that had at least one person age 65 or over and on Medicare were accepted into the sample. Individuals who were dually eligible for Medicare and Medicaid were not interviewed because they do not normally purchase private health insurance to supplement Medicare.

Response Analysis was able to ascertain eligibility information for 71% of the telephone numbers that were determined to be for residential households with working telephones. The majority of the remaining 29% hung up before or during the screening interview. Of the households for which it was possible to establish eligibility, 85% did not have anyone age 65 or older, and a few others were excluded because the elderly residents were not eligible for Medicare or were dually eligible for Medicare and Medicaid. Of the households that met all of our eligibility standards, 68% completed the interview. On average, there were six calls necessary per completed interview; the interviews themselves lasted an average of 19 minutes. To ensure the representativeness of the sample, when there was more than one person age 65 or older in the household, the person with the next birthday was chosen for the interview.

Of the 500 completed interviews, 391 (78%) owned private insurance to supplement Medicare and 109 did not. In order to assess the impact of respondents' level of understanding of the recent changes in Medicare, a "split-sample" technique was employed. Half of the private insurance owners were briefed by the interviewer on the details of the new legislation's benefits, and the other half were not. Instead, they were quizzed to determine their level of understanding. Nonowners were not briefed and therefore were given the quiz.

One interesting aspect of the survey was that elderly respondents were asked whether they or someone else was more familiar with their private health insurance policies. If someone else was said to be more familiar, then an attempt was made to contact that person to find out the desired information about health insurance coverage, including whether the original respondent was likely to drop his or her health insurance policy in the wake of the MCCA. Curiously, only 14 of the 391 policy owners said that someone else was more familiar with their insurance. In these cases, we used the information from the original elderly respondent to construct all variables except those concerning their experience and satisfaction with private health insurance. We suspect that the reason that so few people claimed that someone else was primarily responsible for insurance decisions was that the question was asked well after the interview had begun, and respondents were reluctant to admit that they were not the best person to speak with.

Table 1.—CHARACTERISTICS OF THE SAMPLE COMPARED TO THE ELDERLY POPULATION AS A WHOLE

Demographic Characteristic	Our Sample (percent)	National Sample[1] (percent)
Age:		
65–74	65.2	59.3

Table 1.—CHARACTERISTICS OF THE SAMPLE COMPARED TO THE ELDERLY POPULATION AS A WHOLE—Continued

Demographic Characteristic	Our Sample (percent)	National Sample[1] (percent)
75 and over	34.8	40.7
Sex:		
Male	33.6	40.6
Female	66.4	59.4
Race:		
Black	5.8	8.4
Hispanic	0.4	3.0
Other	93.8	88.6
Marital Status:		
Married	47.9	55.7
Unmarried	52.1	44.3
Education:		
0-11 Years	38.2	48.8
High School Grad	32.1	30.8
Some College	29.7	20.3
Employment Status:		
Employed	7.7	10.7
Not Employed	92.3	89.3

[1] Source: ***Statistical Abstract of the United States***, 1989 (see note 4).

Table 1 shows some of the characteristics of our sample, in comparison with national figures published in the *Statistical Abstract of the United States.*[4] Although our sample does differ somewhat from the national figures, no clear pattern emerges. Compared to the national figures, our respondents were more likely to be (or claim to be) somewhat younger, female, white, unmarried, better educated, and not employed. Some of the differences probably can be explained by the nature of the telephone survey. For example, Hispanics may be under represented because of language problems over the telephone, and younger Medicare beneficiaries might be over represented because they are more likely to live in private residences. Other differences, however, are more perplexing. For example, it is odd that our sample exhibits traits that are indicative of both higher economic status (e.g., more education) as well as lower economic status (e.g., female, unmarried). One possibility is that respondents were less truthful about some personal characteristics (particularly, education) to our interviewers than they may be to census takers. The reason that our survey may have over represented females (and therefore, probably the unmarried as well) may have been that females were more likely to answer the phone and were more willing to be interviewed. Although an attempt at randomization was made by asking to interview the elderly person with the next birthday, it is possible that in some cases this was not followed by respondents. Finally, since our sample was the result of a random selection process, some difference from census figures is to be expected.

FINDINGS: THE MEDICARE PROGRAM

The Elderly's Knowledge of the Recent Changes in Medicare

One purpose of the survey was to ascertain the degree to which the elderly understand the recent changes in Medicare. On the one hand, one might expect their knowledge levels to be high given the intensive amount of press coverage concerning the changes. On the other hand, previous research has shown that the elderly appear to understand few of the specifics of their Medicare coverage.[5]

To assess knowledge, we asked nine questions about the recent changes in Medicare to 303 individuals: the half of the split sample of owners whom we did not brief (N=194), and those who did not own private insurance policies (N=109). For each item, the respondent was asked to indicate whether the statement was correct, incorrect, or that he or she did not know. We explicitly gave the "Don't Know" choice so that we could reduce the amount of guessing, and therefore better gauge true knowledge levels.

The nine questions (with answers in brackets) represented six aspects of the legislation:

Hospital Coverage

- With the new catastrophic coverage, Medicare will cover all costs of a hospital stay, except for an initial payment of about $500 [True].

Physician Coverage

- Medicare will cover all costs that your physician charges you for services [False].
- Medicare will cover all reasonable costs of physician services after the first $1,400 or so per year is paid [True].

Nursing Home Coverage

- Medicare will cover most of the costs associated with a six-month nursing home stay [False].

Prescription Drug Coverage

- When the new legislation is fully phased in, Medicare will cover some of the costs associated with prescription drugs [True].
- Medicare will pay 80% in of all reasonable prescription drug costs during a year [False].

Spousal Impoverishment

- Medicare will provide some protection to the husband or wife of a nursing home patient to avoid loss of all of his or her assets in paying for nursing home care [True].

Financing

- All people who have Medicare will be required to contribute toward the cost of the new Medicare benefits through an increase in the monthly premium [True].
- All people who have Medicare will be required to contribute towards the cost of the new Medicare benefits through an increase in their Federal tax payments [False].

We constructed these questions because they seemed to capture the primary aspects of the new legislation. Admittedly, some of the issues are not as cut-and-dried as we indicate. For example, only those above the Federal poverty level are required to contribute $4 a month in additional premiums; we did not believe that this nuance would affect our results, particularly because people who received Medicaid benefits were excluded from the survey. Another example concerns the nursing home benefit. Although the new legislation could, in theory, provide coverage for up to five months, the press has made it clear that the vast majority of nursing home stays still will not qualify for Medicare coverage.

Table 2 shots the percentage of sample members who responded correctly to each question. What is most noteworthy are the extraordinarily low knowledge levels exhibited. For the nine questions, the average percentage of correct answers was only 28%. Knowledge levels varied a great deal, however, from question to question. For example, 47% knew that Medicare did not cover all physician charges, but only an astoundingly low 9% were aware that not everyone had to pay more in Federal taxes to finance the program.

Other findings were just as surprising. For example, in spite of the fact that much of the debate on the MCCA centered on Medicare's lack of coverage for long-term nursing home care, only 19% of respondents knew that Medicare would not cover most of the costs of a six-month nursing home stay. Many observers would claim that the centerpiece of the new legislation is prescription drug coverage, yet only 39% knew that Medicare was planning to include any such benefits.

Table 2.—PERCENTAGE OF ELDERLY CORRECTLY ANSWERING SELECTED QUESTIONS ABOUT THE MEDICARE CATASTROPHIC COVERAGE ACT

Item	Percent of Responses Correct
Covers all hospital costs except deductible	34.1
Doesn't cover all physician charges	46.5
Covers all reasonable charges after $1,400	15.5
Doesn't cover most costs of six month nursing home stay	19.1
Covers some prescription drug costs	38.6
Doesn't cover 80% of all prescription drug costs	23.5

Table 2.—PERCENTAGE OF ELDERLY CORRECTLY ANSWERING SELECTED QUESTIONS ABOUT THE MEDICARE CATASTROPHIC COVERAGE ACT—Continued

Item	Percent of Responses Correct
Provides spousal impoverishment protection	18.5
All must pay monthly premium	48.5
All do not have to pay additional income taxes	8.9

We conducted statistical tests (t-tests and one-way analysis of variance) to determine if there were differences in knowledge levels by a number of characteristics. We found (with significance levels in parentheses) that those with the highest scores were younger (10%), married (1%), Caucasian (1%), better educated (1%), and wealthier beneficiaries (1%). Not surprisingly, education was a particularly important determinant of knowledge. For example, beneficiaries who had attended at least some college correctly answered an average of 3.5 questions right, compared to only 1.7 for those who did not finish high school. Nevertheless, the fact that the best educated of the elderly correctly answered only about one-third of the questions underscores how poor knowledge levels really are.

We came away from this part of the survey with a sense of disappointment. As we will report next, the elderly have formulated opinions about the MCCA; unfortunately, these opinions appear to be based on ignorance rather than facts. Given that this piece of legislation has received an unprecedented amount of press coverage—beginning with the Bowen Commission study a year before passage of the legislation and continuing to this day —it is indeed surprising how little of this information has been assimilated.

Concern About the Remaining Gaps in Medicare

We asked respondents six questions regarding their concern about some of the gaps that remain in Medicare even after passage of the MCCA. These questions were asked of all 500 respondents. (Owners of private policies were asked what their level of concern would be if they did not have any insurance to supplement Medicare.) Respondents were given four choices: "very concerned," "somewhat concerned," "not too concerned," and "not at all concerned." The specific expenses addressed were:

- the first $560 of a hospital stay
- the $1,400 in Part B payments
- doctor bills higher than the Medicare allowed amount
- the first $600 in prescription drug costs
- paying for a long nursing home stay
- paying for dental care

Figure 1 shows the proportion of respondents who were either very concerned or somewhat concerned about these expenses. The message that emerges is that the elderly are very worried about incurring out-of-pocket costs. Stated in a different way, it appears that they strongly desire first-dollar coverage, which probably helps explain why we later find that so few plan to drop their private insurance coverage in the wake of the MCCA.

Looking just at the proportion of the sample who said they were "very concerned," it is perhaps not surprising that 78% expressed this feeling about long nursing home stays, and even that 71% felt that way about excessive physician charges. Both of these expenses are unknowns, and therefore have the potential of causing great financial hardship. What was more surprising to us was the concern expressed over expenses that were fixed and, by most standards, not terribly high, especially when compared to supplemental health insurance premiums. (As discussed later, our respondents reported paying mean annual premiums of $718). For example, two-third (66%) were very concerned about the first $600 of prescription drug costs, and 56% were very concerned about the hospital deductible.

We do not mean to imply that the elderly are mistaken in their concern—obviously, it is a subjective assessment. Rather, what emerges from the findings thus far is a group of people whose understanding of the Medicare program is weak, and who appear deal with the resulting uncertainty by desiring coverage for any remaining gaps. The fact that they are so concerned with those gaps that still remain in Medicare is consistent with the hypothesis that they will want to retain their private supplemental insurance, an issue addressed later.

We conducted chi-square tests to examine variables associated with the level of concern. Not surprisingly, the most consistent finding was that. people with lower incomes tended to be more concerned about all of the gaps that remain in Medicare. For example, whereas 73% of those with annual incomes below $10,000 said they were "very concerned" about the $560 Part A deductible, this was true of only about 36% of those with incomes above $20,000. Two other fairly consistent findings across the six "concern" questions were that younger beneficiaries were more concerned than their older counterparts, particularly with regard to long nursing home stays, and that the less educated were more concerned about Medicare's gaps as well. We have no ready explanation as to why younger beneficiaries expressed a greater degree of concern than their older counterparts. Another curious finding was that whites expressed more fear than nonwhites about the costs of long nursing home stays, but less concern about dental costs.

Attitudes About Medicare and the Medicare Catastrophic Coverage Act

We asked respondents questions concerning their satisfaction with Medicare benefits and costs both before and after the recent changes. This is the first instance in which our split-sample technique becomes important. Here, we are particularly interested in whether those to whom we explained the changes in Medicare's benefits responded more positively than those in the control group, who did not receive an explanation of the new benefits. We confine our results to the 78% of respondents who owned private insurance.

Respondents were asked five questions concerning their satisfaction with Medicare:

- how satisfied they were with Medicare's benefits before the legislation
- how satisfied they are in program benefits after the legislation
- how satisfied they were with Medicare premium costs before the legislation
- how satisfied they are with Medicare premium costs and any additional income taxes they may have to pay after the legislation
- their overall opinion of the legislation

For each of the first four questions, respondents were given four choices: "very satisfied," "somewhat satisfied," "not too satisfied," and "not at all satisfied." For purposes of presentation for the first four questions, we have combined the first two into an overall "satisfied" category, and eliminated any "Don't Know" responses so that the percentages indicate the level of satisfaction among those who ventured an opinion.

Figure 2 shows satisfaction levels with Medicare benefits before and after the legislation. One of our most unexpected findings was that among both the briefed and control groups, respondents indicated more satisfaction with Medicare benefits before these benefits were expanded. In both groups, approval levels declined by more than ten percentage points. The findings with regard to costs are shown in Figure 3. Whereas over 70% of respondents were satisfied with their payments before the legislation, this fell precipitously, to around 30%, afterwards. Furthermore, similar levels of dissatisfaction were recorded among different income levels. We believe that this strong dissatisfaction with the financing side of catastrophic has colored the elderly's view of the benefits, which might explain the anomalous result that they preferred the old, more limited Medicare benefit package.

We conducted chi-square tests to determine characteristics associated with Medicare satisfaction, and found (with level of significance in parentheses) that high school graduates were more satisfied with both the benefits (1%) and costs (1%) of their policies, but that those who said they were in only fair or poor health were less satisfied both with policy benefits (1%) and costs (5%).

An issue that has received a great deal of attention is whether or not most elderly' people approve overall of the recent changes. To address this, we asked respondents:

> Taking into account both the benefits and costs [of the MCCA] to you, which of the following describes your opinion about the changes in Medicare? Do you (1) strongly support the changes, (2) support the changes somewhat, (3) oppose the changes somewhat, or (4) strongly oppose the changes?

Table 3 presents the results for each of three groups: the briefed owners of private insurance, the control group of owners, and non-owners. Looking first at the overall results in the last column, most of those who ventured an opinion oppose the legislation. Whereas 33% of respondents are strongly or somewhat supportive of the changes, 42% strongly or somewhat oppose the changes. Furthermore, there appears to be more fervor among the opponents: Whereas 7% are strongly supportive, 24% are strongly in opposition. About one-fourth of respondents did not venture an opinion. Chi-square tests of significance found no variables to be significantly associated with respondents' overall opinions of the legislation.

Table 3.—OVERALL OPINION ABOUT THE MEDICARE CATASTROPHIC COVERAGE ACT

[In percent]

	Briefed Owners	Control Group Owners	Non-Owners	Total
Strongly Support	9.2	6.7	5.5	7.4
Somewhat Support	24.5	27.8	24.8	25.9
Somewhat Oppose	21.9	17.5	11.9	18.0
Strongly Oppose	25.0	25.8	18.3	23.9
Don't Know	19.4	22.2	39.4	24.9

No clear pattern emerges from the split sample. When people are given information about the changes in Medicare's benefits, they do not appear to be more in favor of the legislation than do members of a control group. In and of itself, this implies that public support may not grow very much as people become more familiar with the MCCA.

FINDINGS: THE PRIVATE INSURANCE MARKET

Private Supplemental Insurance Policies and Their Owners

Number of Policies Owned.—Figure 4 shows the percentage of sample members who owned policies, as well as the percentage of policy owners who owned more than one policy. It must be remembered that we excluded individuals who were jointly eligible for Medicare and Medicaid, which raises ownership rates because those eligible for Medicaid typically do not purchase private coverage. We found that 78% of the elderly own policies. When one takes into account our exclusion of joint Medicare/Medicaid eligibles, our figure is identical to estimates make by Congressional Budget Office.[6]

Approximately 85% of owners said they owned one supplemental policy, with the remaining 15% claiming to own two or more. Only 10 sample members (2.6% of owners) reported owning three or more policies; one sample member claimed to own as many as six.

There have been a number of studies conducted previously on the characteristics of policy owners and nonowners.[7] Our results are consistent with most of these other studies. We performed chi-square tests and found that the following groups were most likely to own one or more policies (significance level in parentheses): individuals age 80 and under (10%), whites (1%), married (5%), better educated (1%), higher incomes (1%), and those reporting better health status (10%). Although most of the differences were not terribly great, race was a notable exception. Whereas 82% of whites owned policies, only 33% of nonwhites did. The pattern with regard to income was also interesting. Although those with higher incomes were more likely to own private policies, there was no relationship between ownership and income for income levels beyond $10,000. These patterns with regard to both race and income are consistent with previous studies on the determinants of policy ownership.[8]

We also conducted chi-square tests to determine what factors were associated with owning multiple policies. The only demographic or health status measures that were statistically significant (level of significance in parentheses) were: those with higher incomes were more likely to own multiple policies (5%); and those who visited the doctor more in the previous year were more likely to own more than one policy (10%). This latter finding may simply indicate a utilization response: people who purchase more than one policy may demand more physician visits.

Premiums.—The mean and median annual premiums for private supplemental insurance policies reported by respondents is shown in Figure 5. The mean was $718, and the median, $640. The Congressional Budget Office estimated that the typical premium for a Medigap-type policy was $542 in 1987.[9] Our higher figures reflect the much-publicized fact that policy premiums have risen substantially since that time.[10] We conducted t-tests on a number of individual characteristics that we thought might be associated with higher premiums, but could find no variable that was statistically significant, even at the 10% level.

We also asked respondents whether their premiums had increased during the previous 12 months. Although one might question whether respondent recall would be reliable, particularly if the premium were being paid by an employer or former employer, we were interested in determining whether satisfaction with private policies is affected by premium increases (an issue examined later in the findings). Figure 6 shows that a plurality of respondents (47%) indicated that their premium did increase, but a sizable number (40%) said that there was no change or that they actually decreased. Of those reporting a change, the median was about 20%, or $12 a month.

Types of Policies Owned.—Respondents were asked to indicate which of the following statements best described their policy (if they owned more than one policy, questions applied to the one with the highest premiums):

- It pays many of the medical expenses not covered by Medicare; these are sometimes called "Medigap" or "Medicare supplement" policies
- It pays you a fixed amount of money for each day you spend in the hospital
- It pays only for long-term care in a nursing home or care at home
- It pays only if you have a specific disease such as cancer

Figure 7 shows the responses. The large majority of policy owners—89%—reported having Medigap policies. The next highest, 8%, was for hospital indemnity, while only one percent each reported having specified disease or long-term care polices. It is possible that the non-Medigap policies were underreported because, among those people who owned more than one policy, these policies were not their primary policy.

Policy Purchase Methods.—We asked those respondents who did not obtain their policies through an employer or former employer how they purchased their policies. The choices regarding their actual method of payment were: (1) through a group or association; (2) from an insurance company or agent; (3) through the mail, or (4) through an HMO. Figure 8 shows that the vast majority purchased policies through an association or group, or through an insurance company or agent of such a company. Interestingly, only 7% said they received their policy through the mail.

We also asked all respondents their desired method of purchasing a policy if they were doing it again. Not surprisingly, those who received their policies through an association or group preferred that method, whereas those who used an insurance company thought that was best. People who received their policy through an employer or former employer overwhelmingly preferred that method.

Satisfaction with Private Insurance Policies

We asked policy owners several questions about their satisfaction with their private insurance policies. The first two questions concerned satisfaction with policy benefits and costs. Respondents were given four choices: "very satisfied," "somewhat satisfied," "not too satisfied," and "not at all satisfied." (Respondents who answered "Don't Know" have been excluded from these tabulations.) Figure 9 shows that nearly 90% of owners report satisfaction with policy benefits, and almost three-quarters with policy costs. These figures are a little higher than the Medicare satisfaction levels *before* the new legislation reported in Figures 2 and 3, and much higher than current Medicare satisfaction levels. We were curious as to whether satisfaction with costs was correlated with whether the person said his or her policy experienced an increase in premiums during the last 12 months. Not surprisingly, people whose policy premiums had not increased were twice as likely to be "very satisfied" with policy costs (significant at the 1% level).

Another question on the survey asked whether the respondent's private insurance policy "met all your expectations" Figure 10 shows that, for a large majority of owners, their policy did so. Almost three-fourths said that their policy met all expectations, while only 14% said that it did not. (The remaining 12% did not know, possibly because they had not yet used any policy benefits.) Those respondents who said that their policy did not meet all of their expectations were asked where it had failed to do so. The most frequently noted area was physician care, followed by hospital, prescription drugs, and dental services.

The Effect the of Medicare Catastrophic Coverage Act on the Private Insurance Market

One of the great unknowns about the MCCA is how it will affect the private insurance market. The legislation does remove some of the reasons that elderly persons might have had for purchasing supplemental coverage. In particular, two glaring "gaps" in Medicare were filled in by the legislation: beneficiaries are no longer at financial risk for hospital stays that exceed 60 days, and there is now a cap on their 20% Part B coinsurance liability. The Medicare prescription drug coverage, when fully implemented, also removes some of the risks of incurring very high levels of out-of-pocket costs.

On the other hand, the legislation comes far from covering all health care costs. There are, of course, the remaining beneficiary financial responsibilities for hospital care ($560), Part B ($1,370) and prescription drugs ($600 plus 20% of additional costs), as well as most nursing home care. Whether these remaining gaps would be sufficient to cause the elderly to retain their supplemental insurance policies was one of the most important research question addressed in the survey.

As before, we employed the split sample technique, to determine if there were differences among those who were briefed about the new Medicare benefits versus those who did not receive additional information. One could argue that the former group's responses might be more predictive of the long-run response, because over time it is likely that the elderly will gain additional knowledge.

Respondents were asked one of two questions, depending on whether they said they owned one policy or more than one policy. If a respondent owned one, we asked:

> What do you think you are likely to do once the new Medicare benefits are fully implemented? Do you plan to keep the additional health insurance policy that supplements Medicare, or do you plan to drop it?

If a respondent owned more than one policy, the wording was:

> Do you plan to keep all of the additional health insurance policies you have that supplement Medicare, drop some of them, or drop all of them?

We have combined answers to these questions into three categories: keep all policies; drop one or more policies; or don't know. Figure 11 shows the response for the two groups, which are nearly identical. The vast majority of respondents over 80% in both groups—reported that they planned to keep their private insurance policies. Only three percent of each group said they planned to drop one or more policies, and about 15% did not know what they would do.

We conducted chi-square tests to examine a number of variables that might be associated with the keep/drop decision, and to our surprise, almost none were. For example, those who were most concerned about the remaining gaps in Medicare appeared no more likely to retain their policies than those who were less concerned. There were also no patterns with regard to age or income. Curiously, the only statistically significant finding among the demographic and health status variables was that those who said their health was only "fair" or "poor" were less likely to say they would keep their policy (significant at the 1% level).

Those who are unsatisfied with the private policies, however, are less likely to say that they will retain their policies. Table 4 shows that among the 14% of respondents who reported that their policy did not meet all of their expectations, a full 40% plan to drop a policy or do not know whether they will, versus only 14% for those whose policy has met all expectations (significant at the 1% level).

Putting these findings together, it appears that the primary reason explaining why some individuals may not retain their private insurance policies is not because of the MCCA's benefits, but because they are unsatisfied with the private insurance policies. One could easily imagine these people purchasing another policy to replace their current one. Thus, it appears that in and of itself, the catastrophic legislation will have little overall impact on the private supplemental insurance market, although one must interpret these results with some caution as it may be too early for most people to have made final decisions about their insurance.

Table 4.—PERCENTAGE OF PRIVATE POLICY OWNERS WHO PLAN TO KEEP OR DROP THEIR POLICIES, BY WHETHER THEIR POLICIES MET ALL OF THEIR EXPECTATIONS

[In percent]

	Policy Met All Expectations	Policy Did Not Meet All Expectations
Plan to Keep Policies	86.5	60.4
Plan to Drop Policies	1.1	13.2
Don't Know	12.4	26.4

CONCLUSIONS

There are three overall findings from the survey. First, the elderly know very little about specific Medicare provisions, although what they've heard makes them have serious reservations about the recent legislation. Second, even if one informs them about the extensiveness of Medicare's coverage for acute care services, they are still extremely worried about the remaining gaps, most of which are so-called "first dollar" rather than "catastrophic." Consequently, our third finding is that they plan to retain their private insurance coverage because of their fear of the remaining gaps. In fact, in an open-ended question we asked respondents why they said they would keep their policy, and most referred either to the need for additional protection, or that Medicare did not cover all costs.

Our findings point to the predicament of formulating effective, yet politically acceptable national health policy for the elderly. The tastes, preferences, and knowledge of the elderly revealed in our survey starkly contrast with homo economicus—the rational, calculating and knowledgeable individual that dominates the world of neo-classical economics. Instead, we find a fearful and uninformed individual, highly concerned about any costs which must be paid for out-of-pocket, eager to purchase insurance to protect against even foreseeable expenses. Some fear and ignorance is understandable, given the complexity of the Medicare program, the existence of unforeseeable Medicare gaps, the sheer magnitude of the cost of a major illness, and the confusing array of private insurance policy choices. Indeed, some elderly may cling to their policies in the mistaken belief that they are protected from the most devastating of risks, a long nursing home stay.

Private supplemental health policies help allay some of these fears, which partly explains why the elderly are more satisfied with the costs and benefits of their private health insurance than they are with Medicare. Moreover, market surveys generally indicate that the elderly are uncomfortable with change, which may further exacerbate present ill-feelings towards Medicare. Yet, these tastes for first-dollar coverage and aversion for change suggest that competition advocates who hope to control costs by molding a health care system where beneficiaries are more sensitive to the cost of care, are likely to be frustrated.

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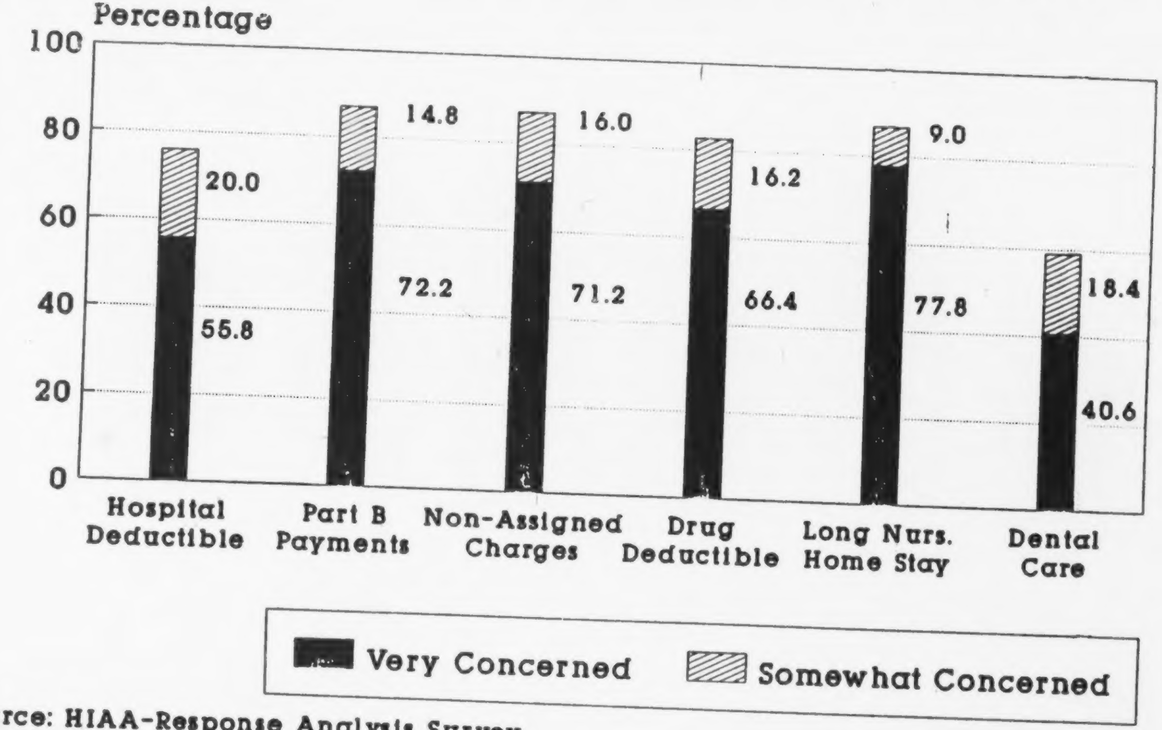
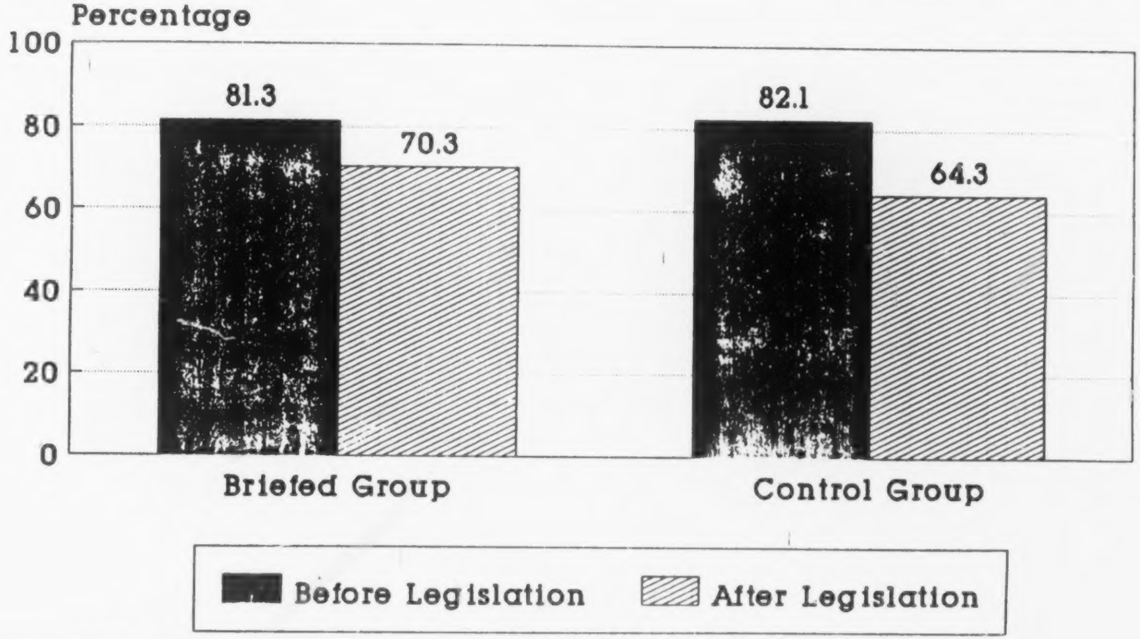
Percentage of Elderly Concerned
About Remaining Gaps in Medicare



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 1

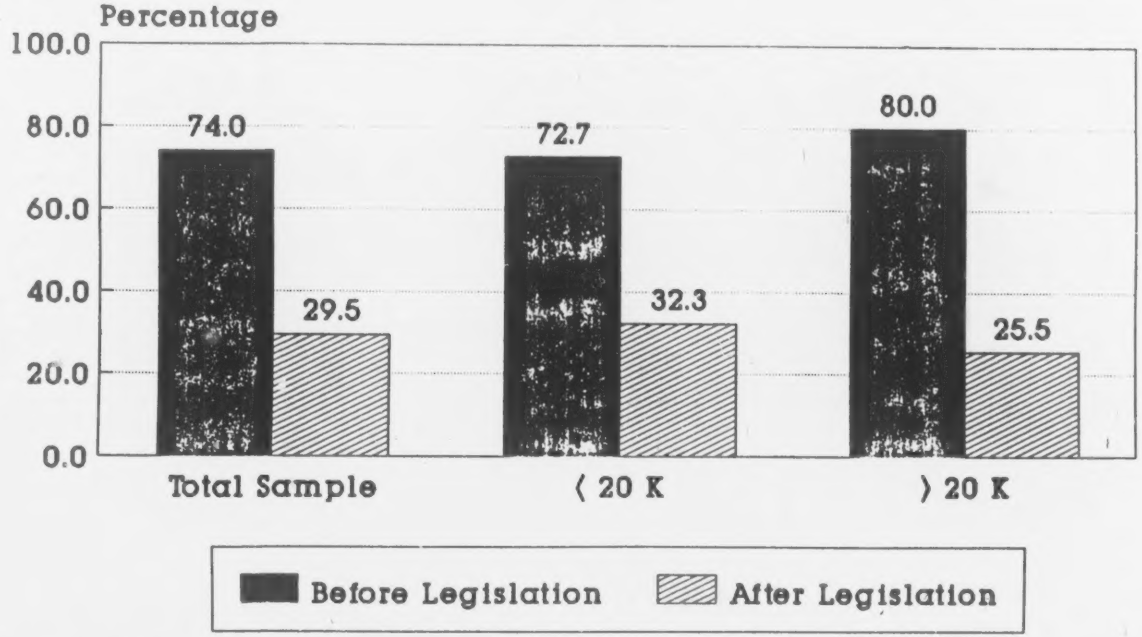
Percentage of the Elderly Satisfied
With Medicare Benefits Before and After
Recent Catastrophic Legislation



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 2

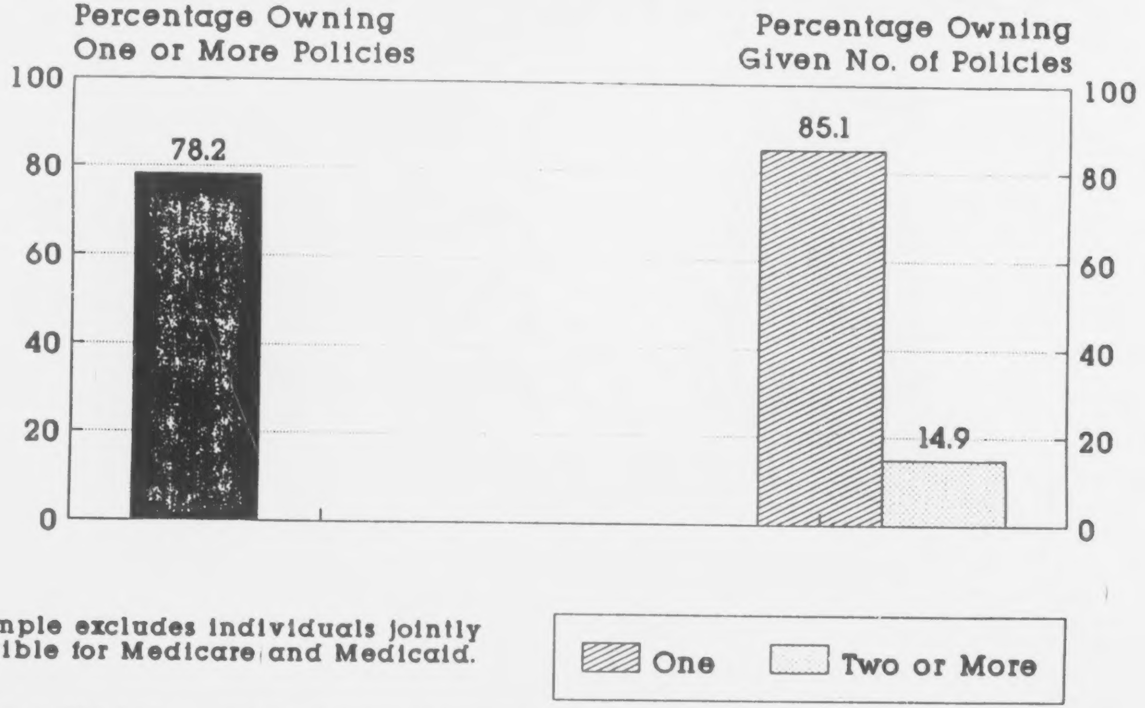
Percentage of the Elderly Satisfied With Medicare Costs Before and After Recent Catastrophic Legislation



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 3

Percentage of Elderly Who Own Private Insurance and Number of Policies Owned *

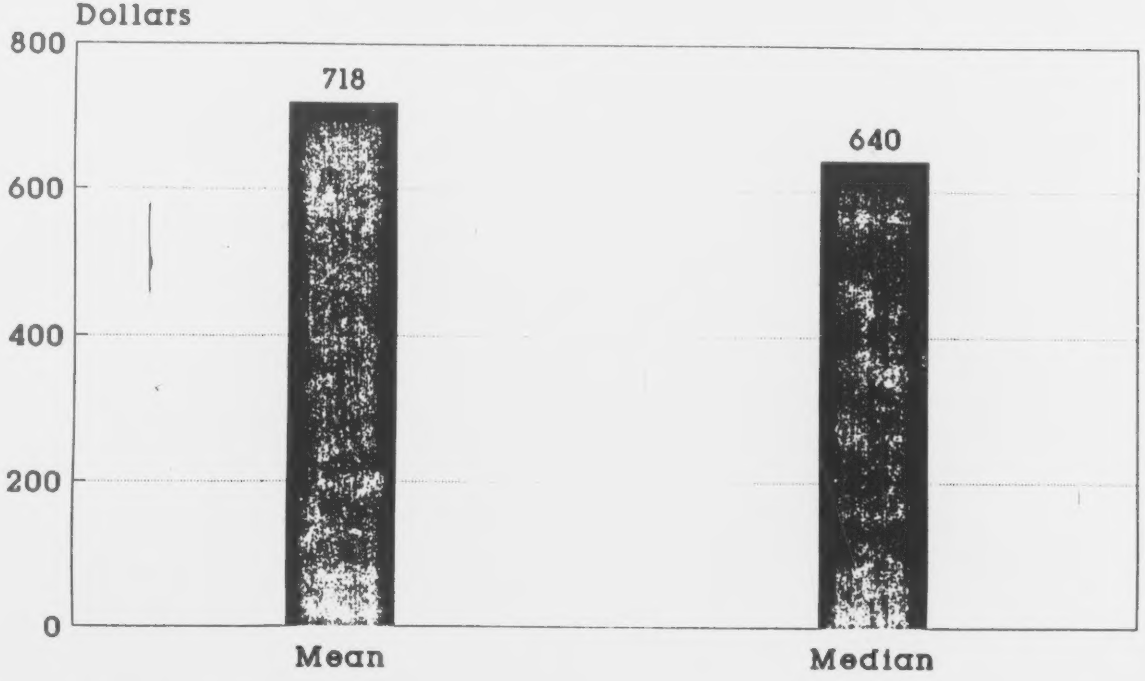


* Sample excludes individuals jointly eligible for Medicare and Medicaid.

Source: HIAA-Response Analysis Survey of 500 Elderly, May 1989

Figure 4

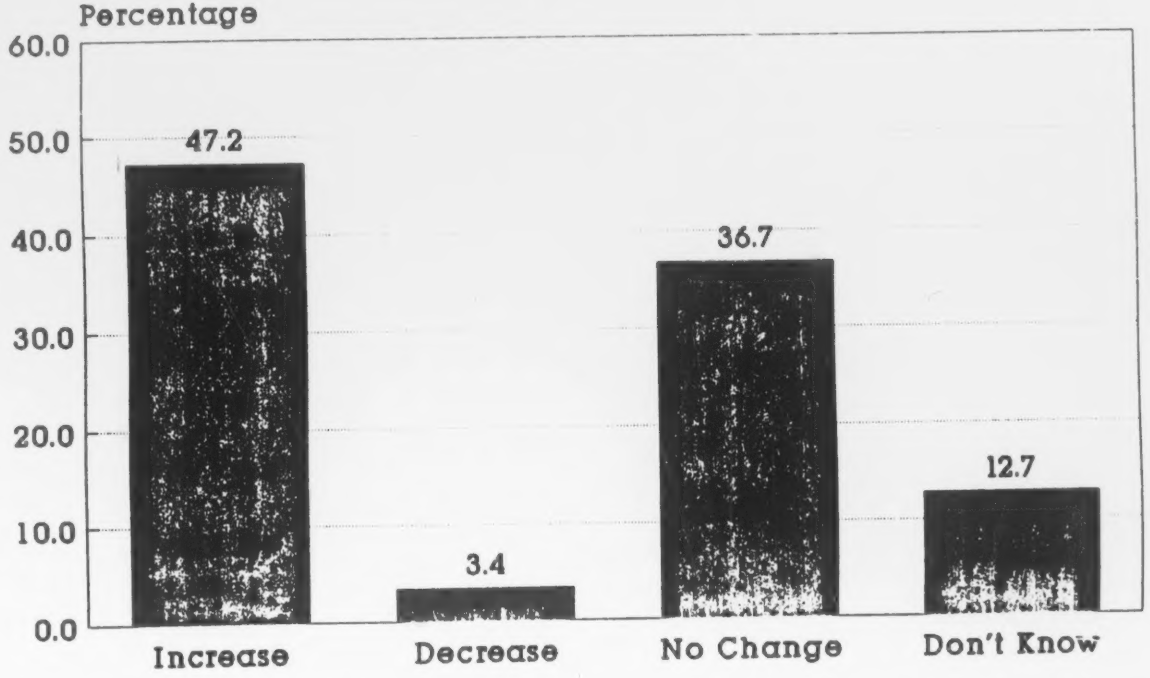
Annual Reported Premiums for Private Supplemental Insurance Policies



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 5

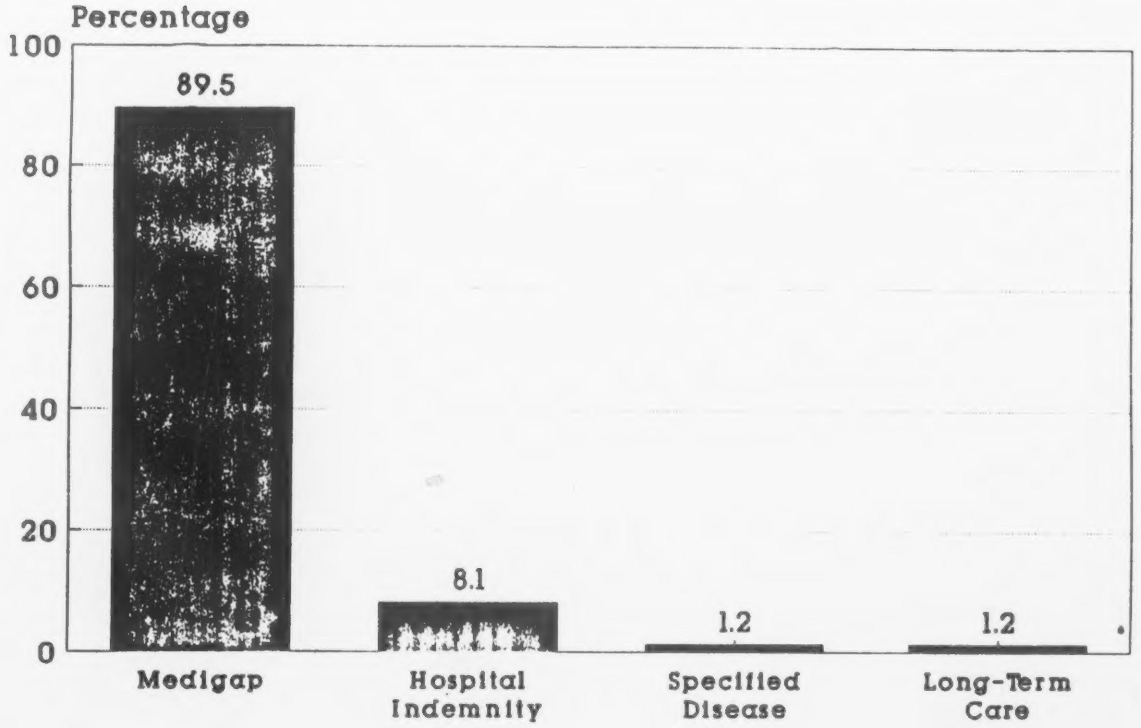
Changes Reported in Policy Premiums During the Last 12 Months



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 6

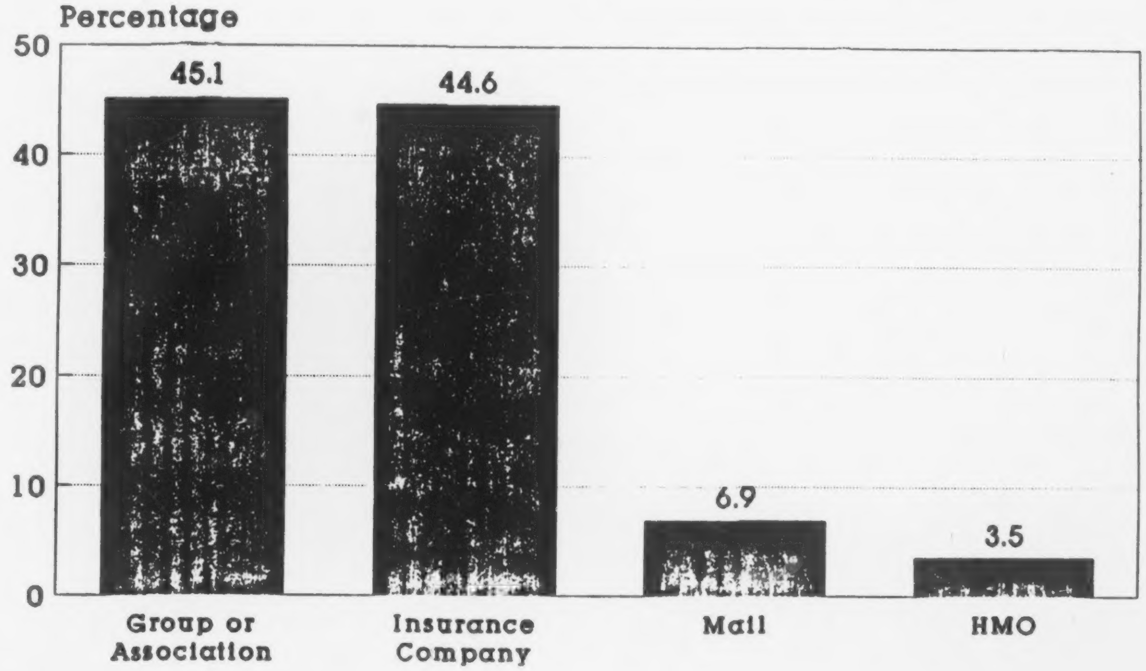
Type of Policy Owned



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 7

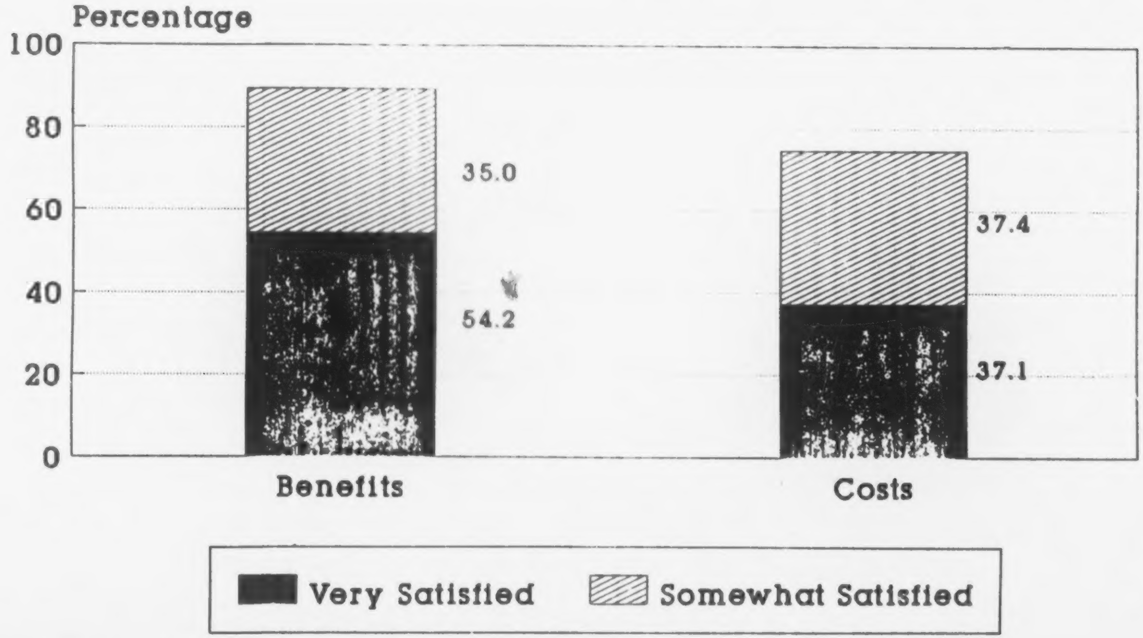
Method of Purchase for Policies Not Obtained Through an Employer



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 8

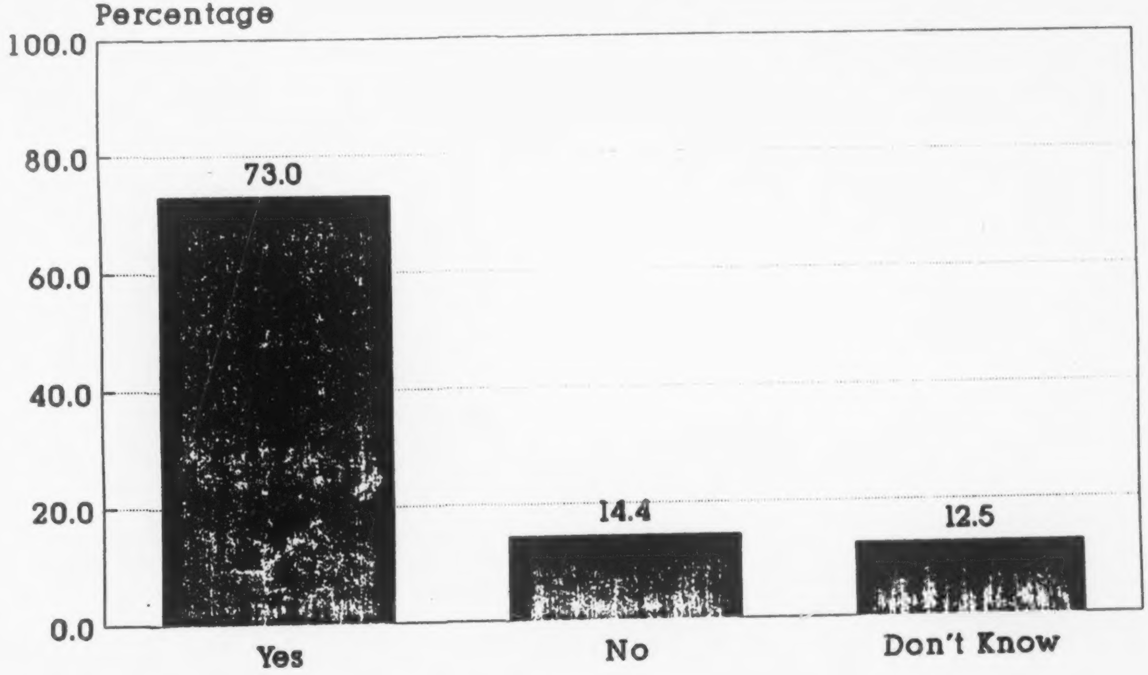
Percentage of Private Insurance Owners Satisfied with Their Policies' Benefits and Costs



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 9

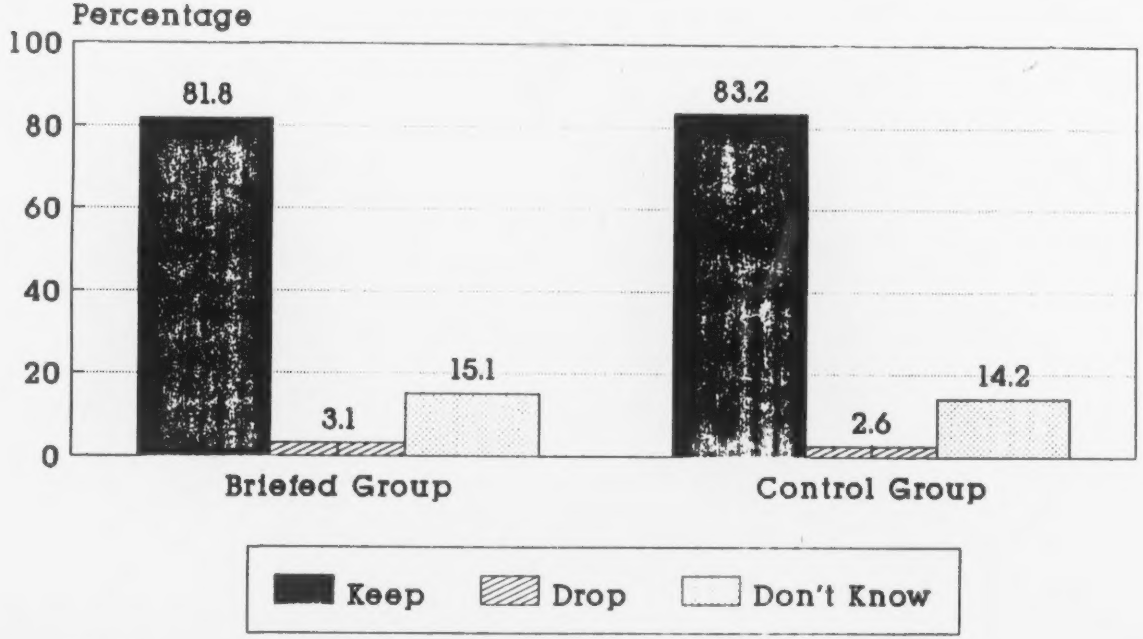
Percentage of Policy Owners Whose Policy Has Met All Expectations



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 10

Percentage of Private Insurance Owners Who Plan to Keep or Drop Their Policies



Source: HIAA-Response Analysis Survey
of 500 Elderly, May 1989

Figure 11

TODAY'S FUTURE DILEMMA: POSTRETIREMENT HEALTH BENEFITS

(Steven DiCarlo, Jon Gabel, Health Insurance Association of America, Gregory de Lissovoy, Judith Kasper, Johns Hopkins University)

Retiree health benefits are steadily becoming a more significant portion of the costs of employer-sponsored health plans. Because of escalating costs, many businesses are considering limiting their liability for retired workers' health care. Several factors make postretirement health benefits (PRHB) the most vexing promise employers have made to employees.

Two factors are preeminent: the accelerating cost of health care and the aging of the population. After implementing cost-containment programs in the mid-1980s, employers were optimistic that health care costs could be controlled. However, confidence has faded with the reappearance of double-digit premium increases. Other factors driving up PRHB costs are expensive new medical technology and the demand that the technology be used without restraint.

The graying of America threatens the solvency of Medicare and employer-sponsored health plans. Even if health care costs could be contained, the sheer numbers of elderly people dictate that PRHB costs will be a greater share of the health care pie. Complicating matters has been the increase in the number of employees who retire before age 65 as firms attempt to reshape their work force.[1] In 1950, working age Americans outnumbered people 65 and over by seven to one. Today this ratio is four to one. By the year 2030, it will be about two to one.[2] With fewer employed workers to finance the cost of the retired population, costs per employee will skyrocket for firms providing PRHBs. Moreover, Americans are living longer. By the year 2030, enough people will be age 100 or more to create three generations of Medicare recipients.[3]

Recent proposed changes in accounting standards rather than demographic trends brought the costs of PRHBs to the forefront. The Financial Accounting Standards Board (FASB) an accounting standards body, formally proposed new rules in February 1989 that will require employers to show future costs of postretirement benefits on an accrued basis.[4] Presently, most employers only show current retiree expenses on a pay-as-you-go basis. For some companies this cost may now be their greatest single liability.[5] The Employee Benefits Research Institute (EBRI) estimates the amount of this unfunded liability for private employers at $169 billion.[6] While this is not a new cost, it illustrates a liability that most firms have yet to confront.

DEVELOPMENT OF PRHBS

PRHBs became popular in the mid-1960s when Medicare was instituted. Because Medicare did not cover all health care costs, businesses and individuals began to supplement Medicare with coverage for uncovered services.

Employers began offering PRHBs in part because of concern for the long-term health of their workers and because it was a more inexpensive form of compensation than wage increases. At the time these promises were made, few foresaw the coming explosion in costs. Employers also believed that this promise of future benefits depended on the welfare of the company and could be easily modified or retracted.[7] Subsequent court cases, such as *Eardmon* v. *Bethlehem Steel* (1984) have largely dispelled this notion.[8] In 1986, the Bureau of Labor Statistics estimated that 76 percent of full-time participants in health plans of medium and large employers had continued health care coverage after retirement.[9]

SURVEY FINDINGS

In 1988 the Health Insurance Association of America (HIAA) and the Johns Hopkins University surveyed employers concerning the types of health benefits offered to active employees. The completed sample represented a national survey of 1,665 randomly selected employers who offered health insurance benefits. The sample included both private and public firms, excluding union and Federal government employees. The response rate exceeded 70 percent.

We then reinterviewed private firms that indicated current coverage of retirees.[10] The retiree survey included questions about eligibility, premium costs, cost sharing, cost-containment provisions and coordination with Medicare. We completed 327 interviews of the firms that provide retiree health benefits—a response rate of 84 percent. Westat, a Maryland-based survey firm, conducted the interviews. The average interview time was 10 to 12 minutes.

Corroborating findings of other surveys, we found that retiree benefits were similar to active employee benefits.[11] The average number of retirees covered by each firm in our survey was 2,079; however, more than 50 percent of these companies covered fewer than 200 retirees. The number of retirees covered ranged from one to

75,000. Of the retirees currently covered by PRHBs, 32 percent were early retirees, and more than two-thirds were age 65 and older (see figure 1). The average length of time employers have offered PRHBs was 21 years. Firms that offer these benefits tended to be well established with only 5 percent having been in business for ten years or less.

Seventy-five percent of the plans required a defined number of years of service before an employee was eligible to receive retiree health benefits, usually the same as required for a pension (see figure 2).

The overwhelming majority (88 percent) of retirees were enrolled in conventional fee-for-service plans; 8 percent were enrolled in PPOs and four percent in HMOs (see figure 3). Of the active employees, 11 percent were enrolled in PPOs and 18 percent in HMOs. Most retirees (94 percent) were covered by the same plans as active workers.

Retiree Costs

The average monthly premium cost for retirees age 65 and older is similar to that of active employees: single coverage for retirees was $100 and family coverage cost $207.12 Employers contributed 85 percent of the single premium and 77 percent for the family premium (see figure 4) Six percent of the retirees paid their premium in full; 44 percent contributed nothing toward their premium. The average rate of increase in premiums between 1987 and 1988 was 11 percent. A large majority (87 percent) of retiree health plans had premium increases in 1988. One percent had a decrease, and 12 percent showed no increase over 1987 (see figure 5).

Retirees differ significantly from current workers in first-dollar coverage payment. More than 40 percent of the retirees covered faced no deductibles, compared with 4 percent of active employees. However, for those who did, the median deductible was $150 for single and $250 for family coverage. This compares to $150 for single and $300 for family deductibles paid by active enrollees.

Benefits

A large majority of retirees (84 percent) received the same benefits and coverage levels as active enrollees. Of those with different levels, just about all received reduced benefits (2 percent received better benefits) Our survey specifically targeted benefits most often needed by retirees. Results show that: 94 percent of retirees were covered for prescription drugs; 91 percent had home health care coverage; 73 percent were covered for hospice care; and 66 percent were covered for skilled nursing care (see figure 6).

A relatively unknown area in PRHBs is the extent to which retirees are subject to cost-containment provisions. Our survey indicates intense cost management activity. Since retirees were enrolled in the same plans as active employees, they were most likely subject to the same restrictions and compliances. Table 1 illustrates the prevalence of each type of cost-containment provision.

Coordination with Medicare

The amount firms pay for benefits of retirees age 65 and older is usually determined by linking the firm's coverage to what Medicare will pay. We asked employers about how they coordinated their plan reimbursements with Medicare (see figure 7) Retirees were most often enrolled in a Medicare carve-out plan (74 percent), where benefits payable are reduced by the amount of the Medicare payment. The second most common plan was coordination of benefits (22 percent), where Medicare payments are applied to the plan's deductible and coinsurance requirements and the employee generally pays no out-of-pocket cost. Exclusion plans (11 percent) were the third most frequently used. This is where a plan subtracts Medicare payments from the total claim before applying deductible and copayment provisions. Medsup plans, those that pay only Medicare deductibles and copayment amounts, accounted for 8 percent. Fixed benefit allowance plans that pay for only specific items or services not covered by Medicare also accounted for 8 percent.[13]

In addition to coordinating with Medicare, our survey reveals that employers paid the full cost of Medicare Part B premiums for more than 40 percent of their retirees. Employers also contributed the total amount of Part B premiums for 34 percent of retiree spouses.

PLAN CHANGES UNDER CONSIDERATION

As health care costs continue to grow and impending regulations and legislation prove burdensome to employers, many analysts predict that firms will make drastic cuts in benefits or eliminate PRHBs altogether.[14] The HIAA-Johns Hopkins Survey asked employers if they plan to drop coverage or if they were considering plan changes. Employers were asked separately about plan changes for current and future retirees age 65 and older, and for early retirees. We found the plan changes for both groups of retirees to be basically the same in most cases.

Contrary to some forecasts, few employers were planning or considering dropping retiree health coverage altogether (see figure 8). Of the firms currently offering PRHBs to retirees age 65 and older, fewer than 5 percent were likely to discontinue offering benefits for future retirees. For early retirees, slightly more were unlikely to continue benefits for future early retirees. We asked if they were considering eliminating spousal or dependent coverage. Only 4 percent were considering this for retirees age 65 and older, less than that were considering this elimination for early retirees. Thus, including employers that plan to drop retiree coverage altogether, roughly 9 percent of the firms surveyed were considering eliminating dependent coverage. There will, however, be changes in the way retiree benefits are structured. Among them are:

- *Increasing retiree contributions for premiums.* Of the firms that do not require retirees to pay the full cost of their coverage, more than half (55 percent) said they will require future retirees to pay a greater share or all of the premium. Sixteen percent anticipate requiring retirees to contribute the full cost. Similar findings were seen with retiree contributions for spousal or dependent coverage.
- *Increasing retiree cost-sharing.* One-third of the employers planned to increase retiree cost sharing by instituting higher deductibles and coinsurance rates.
- *Expanding the use of managed care plans, such as HMOs and PPOs.* Of those firms that do not currently make these plans available to retirees, 40 percent said they were planning or considering this for early retirees. Thirty-six percent indicated this as a possibility for older retirees.
- *Tightening eligibility.* Three out of 10 employers said they were planning or considering tightening eligibility, such as changing the minimum numbers of years of service.

Employers were reluctant to reduce or cut current benefits. Only 15 percent were planning or considering reducing benefits for future retirees age 65 and older. Slightly more than 10 percent will take this action for early retirees.

There is much uncertainty and volatility in the courts regarding promises employers make to employees about benefits. At issue is whether firms have made contractual agreements with employees and to what extent the promised benefits should provide coverage. Thus far, the courts have ruled both ways concerning these issues. Given this uncertainty, experts speculate that employers will be leery of changing the health plans of current retirees.[15] However, our survey revealed that 16 percent of employers plan to change the health benefits available to current retirees.

OUTLOOK FOR RETIREE HEALTH COSTS

Rising health care costs and the expectation of having to account for future retiree expenses, have many employers considering options to reduce their liability towards PRHB plans. Based on our survey, the two most likely strategies employers will use are managed care and increasing the amount that retirees pay for their own care. More and more firms are making available HMOs and PPOs for their retirees. While this is still mostly voluntary, financial incentives alone are likely to make these plans the only choice in the future. Unfortunately, managed care plans are no longer the panacea they were once thought to be. There are signs that HMOs are reaching maximum efficiency in some areas. For example, recent data suggest that the average number of hospital inpatient days in HMOs has reached its minimum level.[16]

According to our survey, firms are beginning to think about and implement increased cost-sharing requirements by retirees in the form of greater employee contributions for premiums and higher deductibles and coinsurance rates. This has the double effect of immediately reducing employer outlays and subsequently reducing employee utilization.[17] Due to high levels of employer contributions, most Americans do not have a true sense of what their health care costs.[18] There is little financial reward for most employees to seek efficient providers and health plans or to question potentially unnecessary treatments by hospitals and physicians. Requiring retirees and employees to pay more of their own health costs may remedy this.

Yet even if health care costs can be controlled, what can be done about the graying of America? As the baby boom generation moves through its midyears, more Americans are retiring while fewer children are being born. How can society avoid the inevitable financial burden this poses?

One solution is to set aside funds now to pay for future costs. FASB has made a small step in this direction by proposing that employers calculate and report their future liability for retiree benefits. While the proposal stops short of dictating how the obligation is to be funded, the first step must be an understanding of what that expense may be.

Another approach to the problem is for employers to curtail early retirement to at least partially offset the anticipated shortage of new, younger people entering the work force in the next few decades.

Finally, keeping people healthy will reduce health care costs. By introducing wellness programs, employers like Johnson and Johnson and Quaker Oats are encouraging a healthier, more active and less costly work force.[19] While these programs have been geared toward active employees, in the future they can be focused on retirees as well.

If the current generation of workers and businesses does not plan wisely for retirement health costs, it will inevitably pass this financial burden on to its children. However, there will be many fewer working children available to support the ever-increasing number of retired parents and grandparents. Fortunately, at least for the moment there is time to plan a response. The political, economic and social agendas of the coming decade must address this and other issues associated with the cost of retirement so that today's workers can have a comfortable retirement with the expectation that their children's standard of living will continue to rise.

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1. Early retirement programs tend to increase employer health costs because the PRHB expense is carried by a smaller active employee base and results in more administration and higher fixed costs. For more details, see Jonathan Dopkeen, "Postretirement Health Benefits," *Health Services Research,* February 1987, Vol. 21, No. 6, pp. 802–803.

2. U.S. Department of Health and Human Services, press release, July 29, 1988.

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4. For an executive summary of the proposal, see "Executive Summary of FASB Exposure Draft on Accounting for Post Retirement Benefits," *Spenser Research Reports,* December 1988. The complete draft is also available from FASB.

5. See J. Norman, "Retiree Benefits: This Footnote Doesn't Have to Become a Nightmare," *Business Week,* Feb. 27, 1989, p. 39; D. Shalowitz, "FASB's Effect on Profits Illustrated," *Business Insurance,* Feb. 20, 1989.

6. *EBRI Issue Brief,* Employee Benefits Research Institute, November 1988, No. 84.

7. Jonathan Dopkeen, "Postretirement Health Benefits," *Health Services Research,* February 1987, Vol. 21, No. 6, pp. 795–848.

8. In the Bethlehem Steel case, the corporation attempted to change the retiree health plan. The district court ruled that the employer did not clearly retain the right to modify or eliminate these benefits. Bethlehem Steel eventually settled the case, obtaining the plan modifications and establishing a permanent retiree health plan. For additional court cases, see *EBRI Issue Brief,* Employee Benefits Research Institute, November 1987, No. 47.

9. Bureau of Labor Statistics, "Employee Benefits in Medium and Large Firms, 1986," U.S. Department of Labor, Washington, D.C., June 1987, Bulletin 2281.

10. Our data represent employers that currently cover retirees with PRHBs. Most other surveys report benefit levels and cost-sharing features for firms offering PRHBs.

11. Bureau of Labor Statistics, "Employee Benefits in Medium and Large Firms, 1986," U.S. Department of Labor, Washington, D.C., June 1987, Bulletin 2281. Consulting firm studies also confirm this.

12. For more details on the cost of active employees, see J. Gabel, et al., "Employer-Sponsored Health Insurance in America," *Health Affairs,* Summer 1989, Vol. 8, No. 2, pp. 116–128.

13. The reader should note that plan names and definitions usually vary from survey to survey. The definitions should be used for comparison purposes.

14. See A. Bennett, "Firms Stunned by Retiree Health Costs," *Wall Street Journal,* May 24, 1988; J. Geisel, "Accounting Rules Will Trigger Retiree Health Plan Changes," *Business Insurance,* Feb. 20, 1989; F. Swoboda and A. Crenshaw, "Accounting Changes May Force Benefit Cuts," *Washinaton Post,* Feb. 14, 1989; I. Ness, "Critics of New FASB Rule Predict Benefit Cutbacks," *National Underwriter,* Feb. 20, 1989.

15. *EBRI Issue Brief,* Employee Benefits Research Institute, November 1985, No. 47.

16. See "HMO Hospitalization No Longer Falling; Outpatient Visits up 18%," *Healthweek,* March 20, 1989.

17. P. Ginsburg and J. Sunshine, "Cost Management in Employee Health Plans," *The Rand Publication Series,* The Rand Corporation, October 1987.

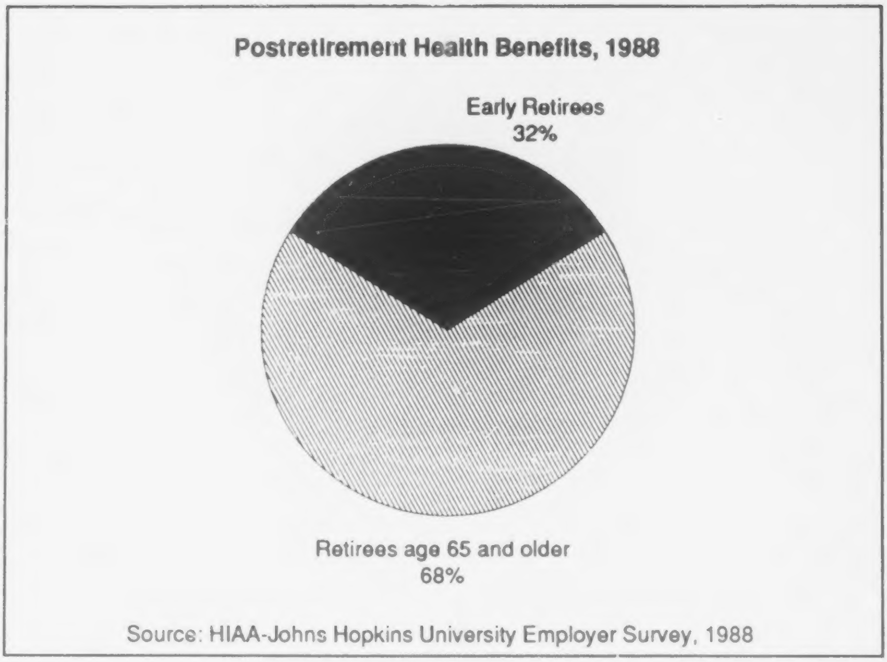
18. Two recent studies document surprisingly little cost sharing on the part of employees. For details, see G. Jensen, M. Morrisey and J. Marcus, "Cost Sharing and the Changing Pattern of Employer-Sponsored Health Benefits," *The Milbank Quarterly,* 1987, Vol. 65, No.4, pp.521–551; S. DiCarlo and J. Gabel, "Conventional Health Insurance: One Decade Later," *Health Care Financing Review,* Spring 1989, Vol. 10, No. 3, pp 77–89.

19. See J. Schwartz and T. Padgett, "'Wellness' Plans: An Ounce of Prevention," *Newsweek,* Jan. 30, 1989; A. Bennett, "Firms Stunned by Retiree Health Costs," *Wall Street Journal,* May 24, 1988.

Table 1.—Cost-Containment Provisions in Postretirement Health Plans, 1988

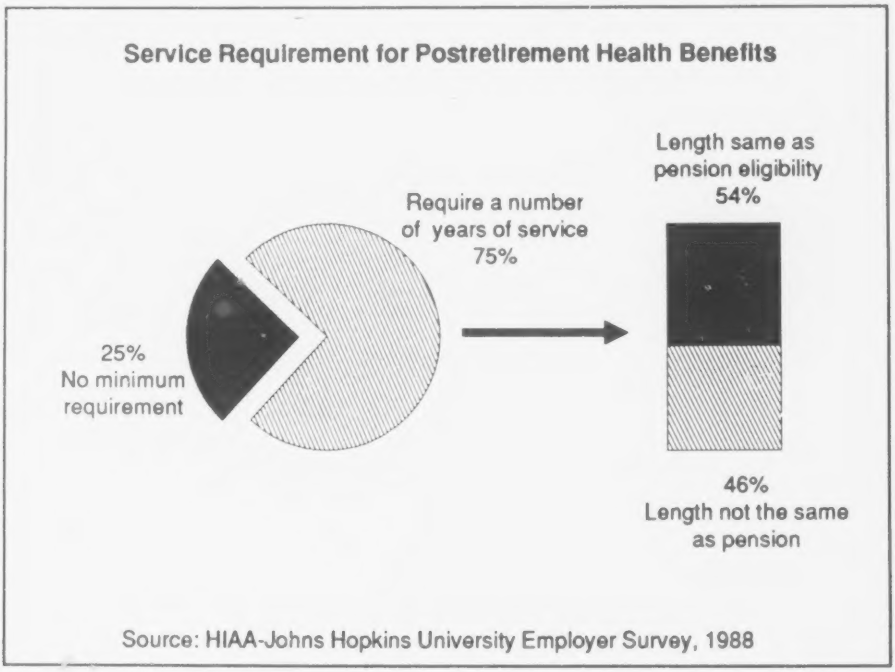
Provision	Percent of Plans
Concurrent Utilization Review	78
Preadmission Certification	76
Case Management for Large Claims	74
Second Surgical Opinion	61
Generic Drugs	19

Source: HIAA-Johns Hopkins Survey, 1988



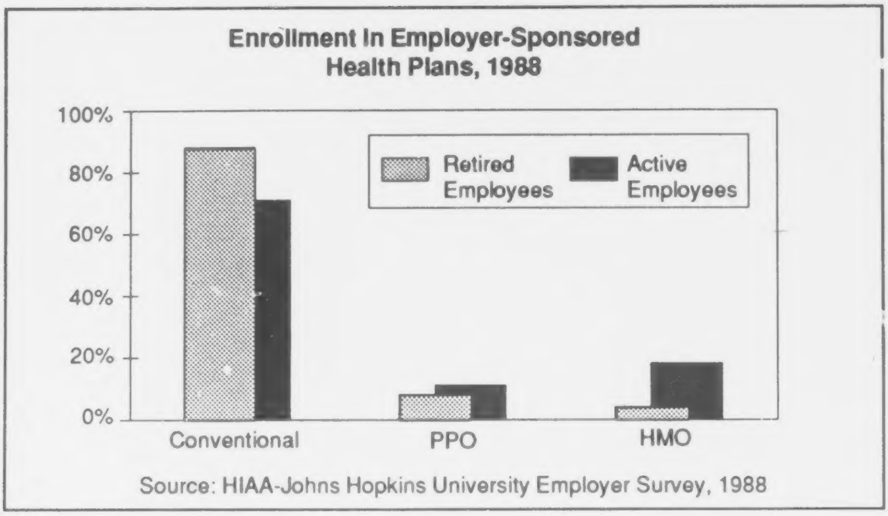
Source: HIAA-Johns Hopkins University Employer Survey, 1988

Figure 1



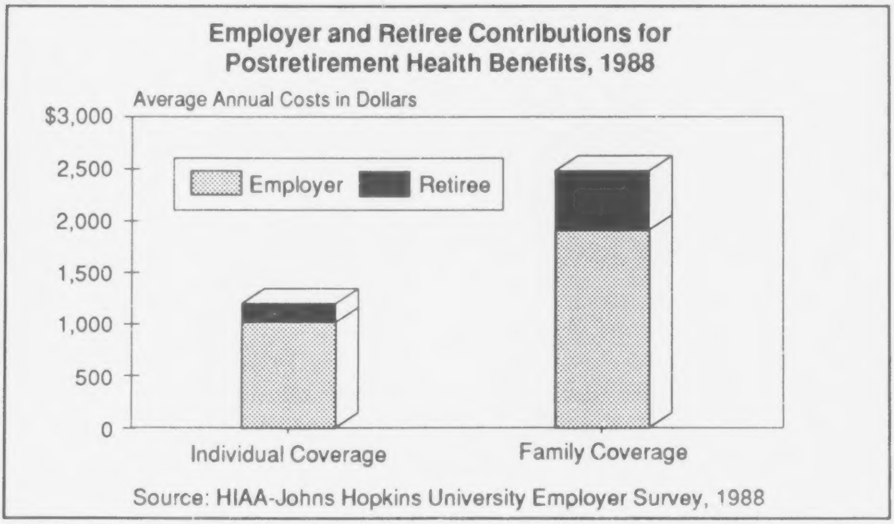
Source: HIAA-Johns Hopkins University Employer Survey, 1988

Figure 2



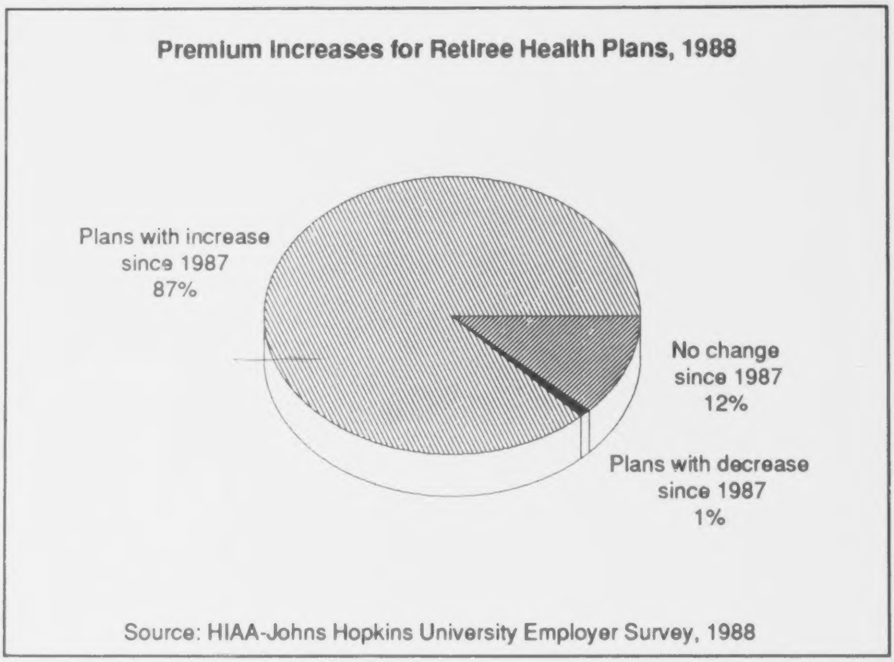
Source: HIAA-Johns Hopkins University Employer Survey, 1988

Figure 3



Source: HIAA-Johns Hopkins University Employer Survey, 1988

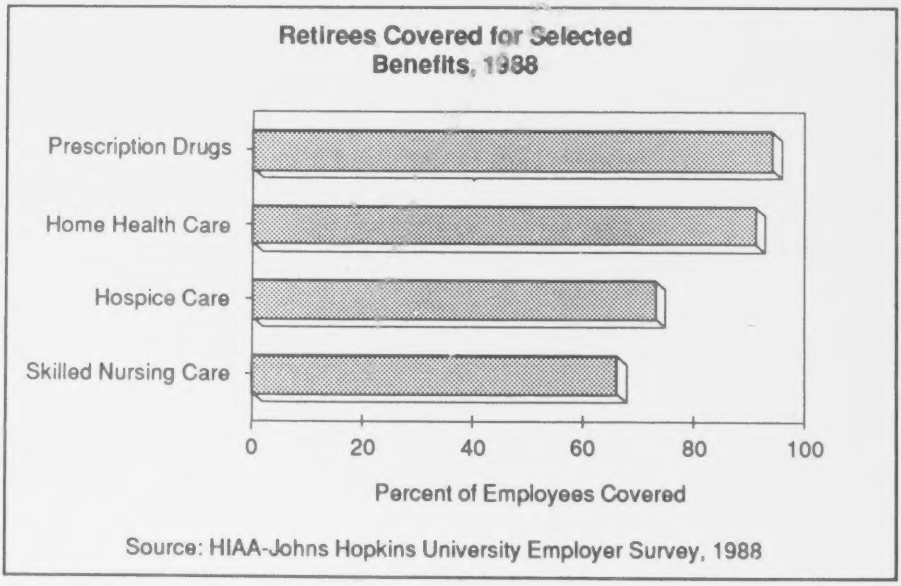
Figure 4



Premium Increases for Retiree Health Plans, 1988

Source: HIAA-Johns Hopkins University Employer Survey, 1988

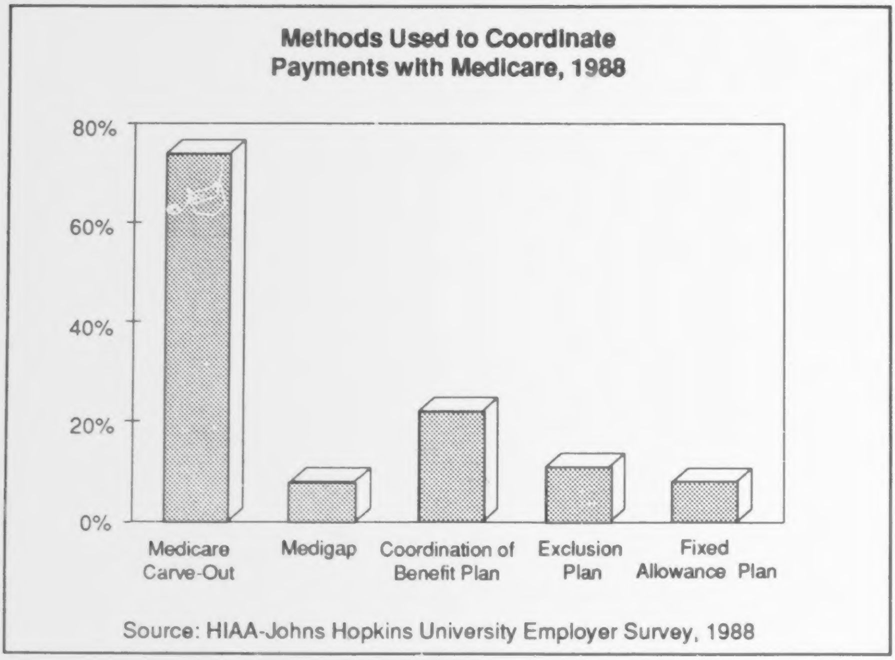
Figure 5



Retirees Covered for Selected Benefits, 1988

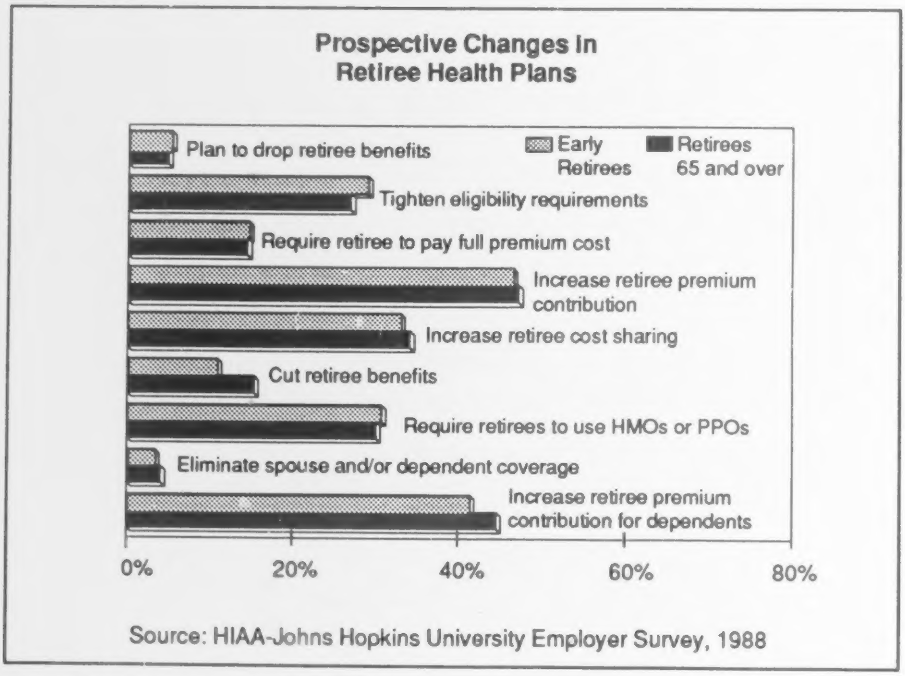
Source: HIAA-Johns Hopkins University Employer Survey, 1988

Figure 6



Source: HIAA-Johns Hopkins University Employer Survey, 1988

Figure 7



Source: HIAA-Johns Hopkins University Employer Survey, 1988

Figure 8

HEALTH INSURANCE ASSOCIATION OF AMERICA

July 25, 1989.

Senator LLOYD BENTSEN,
Senate Committee on Finance,
Dirksen Senate Office Building,
Washington, DC

Dear Senator Bentsen: I am responding to the questions you raised at the July 11 hearing on the Medicare Catastrophic Coverage Act.

You specifically asked that I comment on the recommendations made by the witness from Consumer's Union and Mr. Earl Pomeroy, Insurance Commissioner from North Dakota. Since these witnesses raised several issues, I would like to discuss each in turn.

STATE VS FEDERAL REGULATION

Despite the enactment in 1981 of federal standards for Medicare supplement insurance and the existence of an elaborate system of state regulation of health insurance sold to seniors, isolated cases of inappropriate sales of Medicare supplement policies to the elderly occasionally crop up. However, *no objective assessment has proven that it is a widespread problem and that cases brought to the attention of the appropriate state officials are not being properly investigated and prosecuted.* In fact, state insurance departments report that citizens complaints regarding Medicare supplement insurance are not common.

Positive proposals for addressing reported problems do exist. They are now being addressed by the insurance industry, the National Association of Insurance Commissioners, state insurance regulatory officials and consumer groups representing the elderly. For these reasons we do not believe federal action at this time is necessary.

DUPLICATION OF COVERAGE

The fact is, very few seniors have more than one Medicare supplement policy. In survey after survey we find that 85 percent of seniors have only one health insurance policy in addition to Medicare, i.e., one Medicare supplement policy. Of those who report having more than one policy in addition to Medicare, the vast majority have one Medicare supplement and one hospital indemnity policy.

With few exceptions, it is not generally advisable for a Medicare beneficiary to have more than one qualified Medicare supplement policy. However, millions of American seniors choose to buy a hospital indemnity policy in addition to their Medicare supplement policy. (Unlike Medicare supplement policies which are designed to pay for Medicare's copayments and deductibles, hospital indemnity policies make a specified payment in cash to the policyholders upon proof of hospitalization or illness.) Combining these coverages can be a sound economic decision for seniors who are forced to deal with medical providers who bill patients for amounts in excess of Medicare's allowable rates or who face large cash outlays associated with a major illness or hospitalization. There are also other types of health insurance purchased by the elderly. For example, seniors are increasingly turning to the growing market for long-term care insurance. Many working seniors choose to buy disability insurance in addition to Medicare. Traveling seniors also buy separate private health coverage while overseas.

Since millions of seniors choose to buy such products to complement their Medicare benefits, it seems inappropriate to us to suggest that these options be precluded by regulation or statute.

STANDARDIZATION OF POLICIES

Some have suggested that the Secretary of Health and Human Services should be instructed to write detailed specification for private health insurance policies. The idea of protecting American seniors from the choices that a free-market produces is no less obnoxious when applied to health insurance than it is for other valued goods and services. Spurred by the recent expansion of Medicare, private insurers are now developing new coverage that might appeal to Medicare beneficiaries such as improved vision care, expanded dental benefits, and new ways to cover long-term care bills. This is too dynamic a time to impose federal constrictions. The N.A.I.C. is presently studying methods of enhancing consumer education in this area. We feel the commissioners should be allowed to develop their ideas.

AGENT COMPENSATION

Part of the price for the additional service that customers receive from a professional health insurance agent goes to pay a commission which reflects the time, effort, and skill he or she offers. Appropriate initial compensation is necessary, for that is the point when maximum agent interaction with the policyholder takes place. In order to assure that fair consideration is given to all parties to the insurance transaction, the consumer, the company, and the agent, we suggest that the issue of fair agent compensation be left for state regulation and the N.A.I.C. That is the body with the experience and responsibility for balancing the complex interests involved.

I trust this answers your questions. The staff of the Health Insurance Association of America is ready and eager to be of further assistance on these complex matters. Please don't hesitate to contact me if we can be of help.

Sincerely,

LINDA JENCKES

PREPARED STATEMENT OF MARTHA MCSTEEN

Mr. Chairman, I am Martha McSteen, and as President of the National Committee to Preserve Social Security and Medicare, I appreciate the opportunity to present the views of the National Committee's five million members. Thank you for holding this hearing and continuing to search for solutions to the problems associated with the Medicare Catastrophic Coverage Act.

The Medicare Catastrophic Coverage Act brought to the attention of seniors the enormity of all of the issues surrounding health care: its cost, its quality and its accessibility. Such concerns are familiar to millions of Americans who are not yet eligible for Medicare. The way to resolve the health care problems of all Americans—young and old—is to build on the social insurance foundation.

The National Committee has serious concerns about duplicate coverage and making the coverage voluntary. We believe that the issue can only be resolved by correcting the user-fee financing approach.

DUPLICATE COVERAGE

Prior to the passage of the Medicare Catastrophic Coverage Act, fully one-fourth of Medicare beneficiaries age 65 and over were covered by health insurance programs provided by current or former employers. That, says the Health Insurance Association of America, is in addition to the 50 percent of seniors who had much of the same benefits from their own individual medigap policies. And the 10 percent with the lowest income and least assets received the same benefits through Medicaid. It is for the remaining 15 percent of seniors, that the Medicare Catastrophic Coverage Act carries greatest benefit. To them, it is an extension of our nation's safety net.

Those Medicare beneficiaries paying for medigap policies have undergone a double blow—increased premiums for Medicare and increased premiums for medigap. And, regardless of the provisions of the Medicare Catastrophic Coverage Act, seniors are still faced with considerable out-of-pocket costs.

In the first year of the fully implemented program, seniors could be liable for at least $2,825. And it could be much greater if physician charges are above what Medicare allows. While the catastrophic act disallows duplicate coverage by medigap policies, beneficiaries have yet to see any real reductions in their medigap premiums. Last year's $65 estimated actuarial value of the catastrophic benefits was eaten up by health care inflation and was not reflected in lower medigap premiums. The insurance industry now says that premiums will go down next year when the actuarial value is estimated by the Health Care Financing Administration to be a total of $166. Nonetheless, seniors continue to pay for private insurance as well as increased monthly Medicare premiums and—for about 47 percent—a supplemental tax. And still, seniors remain vulnerable to financial disaster from long-term illness. Any long-term care private coverage must be purchased in addition to medigap and Medicare. For many seniors, such coverage is a luxury they cannot afford.

One National Committee member from Naples, Florida, John McRorie, explains how a fellow retiree under age 65 and former colleague at the USX Corporation pays a lot less for his corporate group health care plan that includes catastrophic illness protection than does Mr. McRorie with his duplicate Medicare catastrophic health coverage. His friend pays $960 a year for full coverage for himself and his wife, while Mr. McRorie and his wife pay $312 a year for an employer-sponsored medigap plan (which includes catastrophic protection) and $765.60 in Medicare Part B premiums including the additional $96 for catastrophic coverage. On top of that, he expects to pay $262 as a result of the supplemental tax. In other words, Mr. McRorie will pay $1,339.60 for the same coverage which costs his non-Medicare eligible retired friend only $960. As Mr. McRorie puts it, "it is horrifying to imagine the financial shock the non-Medicare eligible retiree and his wife are going to get when they reach age 65 and become Medicare eligible."

Mr. McRorie's case is not unusual for those senior workers and retirees with medigap coverage derived from an employer plan. Medicare catastrophic coverage costs them a lot and buys them little if anything.

The one million beneficiaries who have chosen to become part of risk contract health maintenance organizations are particularly frustrated because they already have catastrophic coverage. While the HMO is required to return to members the actuarial value in additional benefits or reduced premiums, for many seniors paying the surtax, it is a poor trade.

For the one million Federal retirees and survivors who are Medicare eligible the catastrophic coverage is also duplicative because they receive such coverage through their Federal health plans. The $3.60 rebate on their annuity checks makes only a small dent in the pain of a surtax for unneeded benefits.

In the long run, employers may be the segment of our economy to benefit the most from the Medicare Catastrophic Coverage Act. EBRI has estimated that the catastrophic legislation reduces employers' liability to current retirees by 30 percent. Quoting from the EBRI report, "Without this adjustment, the current value of privatel corporate liability for retiree health benefits would be $247 billion: $98 billion for current retirees and $149 billion for current workers. Shifting the costs from employers to employees is a straight 30 percent cut in retirement health benefits.

The maintenance-of-effort provision in the catastrophic legislation requires employers to provide additional benefits or a refund if their policies duplicate at least 50 percent of new or improved Medicare benefits. However, this provision is only in effect for two years or until the expiration of the collective bargaining agreement. There is no provision for requiring the employer to continue to give back to current and retired employees the benefit value from the seniors-only financed catastrophic act. In reality, there is probably no effective way to recapture the lost employer benefits.

While we would encourage the Congress to strengthen the current maintenance-of-effort provision, this will only give modest relief to beneficiaries with employer-provided coverage. Most of those paying the surtax will still be worse off. The only way to address the problem is with broad based-based financing.

Duplication of benefits and increased costs still trouble millions of seniors. That includes the one-and-a-half million seniors presently in the work force whose employment related health insurance is primary payor ahead of Medicare.

VOLUNTARY

Several pieces of legislation have been introduced which would include the catastrophic benefits as part of Part B, which is voluntary. In examining the pros and cons of such legislation, I would like to offer the following comments.

There is no question that Medicare Part B coverage is valuable and essential for American seniors. Medicare Part B pays an estimated 46.7 percent of beneficiaries' physician costs, according to a 1989 report by the House Select Committee on Aging.

Recognizing the value of Part B, we then must examine how a voluntary catastrophic benefit package tied to Part B would impact the nation's seniors. Just how "voluntary" would such coverage be? There seems to be little choice for a natural, unconstrained decision. Dropping Part B would just make most seniors worse off. Those opting out would lose valuable Part B benefits while the cost of this protection would undoubtedly increase for those who remain.

Seniors who felt they could not afford any additional expenses from their meager annual budget would likely choose not to purchase catastrophic and Part B. These individuals still in dire need of medical care would then have to turn to Medicaid and Medicaid costs in turn would soar. Still other seniors who may philosophically oppose Medicare would choose not to purchase coverage under an optional plan. Very wealthy seniors might well elect not to purchase coverage under a voluntary plan.

In the long term, if Medicare catastrophic and Part B were tied together as an optional plan for health care protection, one must ask if there would not be an erosion of support for the Part B program. If so, another major health care crisis would exist.

The National Committee believes the solution to the questions being addressed here today lies in replacing the Medicare surtax with general revenues and in the process closing a loophole which gives very wealthy taxpayers a tax break. We strongly support S. 1125, legislation introduced by Senators Harkin and Levin and Representative Bonior which would do just that and at the same time retain all benefits offered under the catastrophic act. The National Committee respectfully urges the Senate Finance Committee to give this legislation favorable consideration this year.

Social insurance programs such as Social Security have always been financed by broad-based taxes rather than "user fees," because these programs benefit all Americans. Medicare not only protects seniors and disabled individuals in ill health, but it also promises protection for today's workers and eases the burdens on families of beneficiaries. "Senior only" financing is like asking only parents to pay for schools or farmers to pay for farm subsidies.

Medicine, health care technology and treatment of disease in this country are uniquely outstanding in the world. Yet, as you know, this country lags behind almost every developed nation in providing adequate health care for all its citizens. Now is not the time to make health care for seniors a greater burden on them individually, but rather to expand the care in a more reasonable economic manner by changing the financing so that it is a shared responsibility among all taxpayers and does not erode the current financial mechanism of Medicare Part B.

Thank you, Mr. Chairman, for the opportunity of testifying before this Committee.

PREPARED STATEMENT OF DAVID NEWHALL, III

Mr. Chairman and members of the Committee: I appreciate the invitation to testify on the Medicare Catastrophic Coverage Act of 1988 in my current capacity as Acting Assistant Secretary of Defense for Health Affairs. You have asked that I address the implications of the Act from the perspective of the Military Health Services System.

The Military Health Services System is dedicated to ensuring that, in time of war, we are capable of providing life saving care to our fighting forces. In peacetime, we are responsible for providing cost-effective, quality medical care to over 9 million beneficiaries. These beneficiaries include active duty and retired members of the Armed Forces and their dependents.

We operate over 500 medical facilities including 130 hospitals within the continental United States. We refer to this network of military medical facilities as the direct care system. In addition to our own health care facilities in the direct care system, we also oversee operation of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) The CHAMPUS program, on a- cost-share basis, reimburses for authorized health care obtained from civilian providers by our beneficiaries, when care is not available in a military treatment facility.

However, it is important to note that, by statute, Medicare beneficiaries are not eligible for CHAMPUS coverage. When a military beneficiary is eligible for Medicare coverage, CHAMPUS eligibility ceases. Eligibility for care in military hospitals and clinics continues beyond age 65, but eligibility does not mean availability. Care is available on a space availability basis that is, "subject to the availability of space and facilities and the capabilities of the medical and dental staff." The commanding officer of each facility determines availability. Emergency care will be provided at all times to eligible beneficiaries. However, when the commanding officer determines that there is not sufficient space, facilities and/or professional staff to provide non-emergency care to all eligible persons, care is provided in the following order of priority:

PRIORITY 1: Active duty service members
PRIORITY 2: Dependents of active duty service members and dependents of members who died while serving on active duty
PRIORITY 3: Retired members, dependents of retired members and dependents of members who died while in a retired status

Of our 9 million plus beneficiary population, slightly more than 720 thousand or 8 percent of our total beneficiaries, are over age 65. This means that of the total 33 million persons affected by the Medicare Catastrophic Coverage Act, slightly more than 2 percent are also eligible to receive care in military medical treatment facilities.

Charges to our beneficiaries at the military hospitals and clinics are minimal. Inpatient care is provided at a rate of $8.05 per day for dependents and a small subsistence charge for military personnel. There is no charge for outpatient care or for prescription drugs. Consequently, military treatment facilities are understandably a popular source of care for eligible retirees and their dependents. Because the care at military facilities is essentially free, this popularity will not be affected by the Medicare Catastrophic Coverage Act. The constraining factor in military treatment facilities for the care sought by Medicare-eligibles is the space available nature of this benefit or geography.

Thus, beneficiaries dually entitled to DoD and Medicare benefits, may receive care in a military facility if that care is available. This varies substantially from one military hospital to another and even from day to day.

Given these parameters, how much care are we at DoD providing to this dually eligible population? Of the total 923 thousand admissions handled by the direct care system in FY 1987, 67 thousand or 7 percent were admissions of beneficiaries over age 65. Based on a 1984 Beneficiary Survey, dually eligible beneficiaries satisfied nearly half of their inpatient hospital care needs in military facilities. Therefore, it is clear that where and when it is available, the military health benefit avoids Medicare program costs and relieves the dually eligible beneficiaries of out-of-pocket costs.

In conclusion, we have no plans to reduce the level or amount of care available for the over 65 beneficiary in military medical facilities. We are trying at least to maintain and, if possible, increase the productivity at all our military treatment facilities. However, I must emphasize that we could never handle the total medical care requirements of this population of over 700,000 persons.

I would be pleased to answer any of your questions.

Prepared Statement of Constance Berry Newman

Mr. Chairman and members of the committee: Thank you for inviting me to join you today. I appreciate the opportunity this hearing will afford to survey the impact of the Medicare catastrophic coverage act of 1988 on individuals subject to employer-sponsored health insurance plans, such as the Federal Employees Health Benefits (FEHB) program which OPM administers, and to evaluate the effectiveness of provisions in that law requiring "maintenance of effort" on the part of employer plans, that is, substitution of additional benefits for coverages newly assumed by Medicare, refunds to Medicare eligibles of the actuarial value of duplicative employer-sponsored benefits, or some combination of these approaches.

Section 422 of the Catastrophic Act requires OPM, in consultation with insurers offering health plans under the FEHB program to establish an FEHB premium reduction with respect to enrollees who are also entitled to primary coverage under both parts A and B of Medicare. The reduction is required to be equal to the estimated cost of medical services and supplies which would have been covered by FEHB plans had Medicare catastrophic benefits not been enacted, prorated by the number of Medicare-eligible FEHB enrollees. For 1989, most of the expanded Medicare coverage is for inpatient hospital benefits under part A, although benefits are also expanded for skilled nursing care, hospice care, and blood transfusions. Expansion of inpatient hospital benefits will not materially reduce out-of-pocket expenses for Medicare-eligible FEHB enrollees because their FEHB plans have typically paid Medicare inpatient deductibles and coinsurance and those plans also waive any FEHB deductibles and coinsurance for such enrollees. OPM's valuation of this duplication of hospital benefits was derived by estimating the percentage of Medicare beneficiaries who could be expected to be saved from either multiple hospital deductibles in the event of more than one hospital confinement each year, coinsurance charges on hospital stays in excess of 60 days, or exhaustion of inpatient benefits. After engaging an independent consultant to assess our computation of the rebate amount, together with insurance carrier comments on its appropriateness, OPM announced in a Federal Register notice dated October 26, 1988, that the 1989 FEHB rate reduction for Medicare-eligible annuitants would amount to $3.10 per month. A general accounting office report dated March 23, 1989, concluded that OPM's rebate determination is consistent with the health care financing administration's projection of the 1989 national average cost of catastrophic coverage changes and appears reasonable.

As the situation now stands, OPM must continue to make rebate determinations under the Catastrophic Coverage Act indefinitely because the FEHB law does not currently authorize OPM to contract for plans expressly designed to supplement Medicare's coverage. Medicare coverage was not even uniformly available to Federal employees until 1983. Most private employers, however, have long adjusted their post-retirement health care plans to explicitly complement Medicare benefits. Even if such employers pay all or a high percentage of health insurance premiums, they find these so-called "medigap" plans advantageous because they are generally cheaper than more comprehensive employee plans and the retirees benefit from coverage more appropriate for their needs.

Section 423 of the Catastrophic Coverage Act required OPM to conduct two studies related to the possible offering of Medicare supplemental plans under the FEHB program and submit them to appropriate congressional committees. One study was to identify FEHB program changes which would be necessary in order to incorporate plans expressly designed to supplement Medicare benefits and to improve the efficiency and effectiveness of this program. The second study called for by section 423 concerned the feasibility of adopting standards issued by the National Association of Insurance Commissions (NAIC) for Medicare supplemental plans in the event such plans are offered to Federal annuitants. OPM prepared a consolidated report on these issues which is dated April 1989.

Under the Catastrophic Coverage Act, the NAIC was given 90 days to issue new minimum standards for Medicare supplemental policies. After reviewing the standards the NAIC adopted in September 1988, OPM concluded that the standards are reasonable and that any product sponsored or made available by the Federal Government for its annuitants should be consistent with them.

Unfortunately, the other issue identified for study cannot be dealt with so quickly. Prior to enactment of the Catastrophic Coverage Act, OPM contracted with an employee benefits consultant for a comprehensive study of the FEHB program. In its final April 1988 report, the consultant recommended a major restructuring of the program to correct serious problems of risk selection and economic inefficiency. as part of an overall reform, the consultant specifically recommended that Medicare-eligible annuitants be removed from the general FEHB risk pool and placed in special Medicare supplemental plans. There are equity issues resulting from the fact that, increasingly, Medicare-eligible annuitants will have been paying taxes for Medicare coverage while still paying FEHB premiums as if Medicare did not exist. However, the primary argument against immediate action to establish special Medicare-supplement plans in the FEHB program—independent of making other necessary structural and substantive changes—is that simply removing Medicare-eligible annuitants from the general risk pool is certain to increase the premiums for the remaining FEHB enrollees and, more importantly, would result in major destabilization in an already precarious program. The destabilization would occur, moreover, at a time of great fiscal constraint when budgetary limitations demand a predictable and controllable level of government expenditures and minimum enrollee increase.

Thank you again. I will be happy to answer any questions you may have at this time.

PREPARED STATEMENT OF EARL R. POMEROY

INTRODUCTION

Mr. Chairman, I am Earl Pomeroy, Vice President of the National Association of Insurance Commissioners (NAIC) and Commissioner of Insurance for the State of North Dakota. The NAIC is a non-profit association whose members are the 50 insurance officials of each state, the District of Columbia, Guam, American Samoa, Puerto Rico and the Virgin Islands.

Thank you for the opportunity to appear today to address regulation of Medicare supplement insurance after passage of the Medicare Catastrophic Coverage Act of 1988 ("Medicare Catastrophic Act"). The purpose of this testimony is to furnish information on (1) the status of state activity, (2) Medicare supplement premiums and (3) ongoing NAIC activities in this area.

I. STATUS OF STATE ACTIVITY

The NAIC developed revisions to its Medicare supplement standards within 90 days of passage of the Medicare Catastrophic Coverage Act of 1988.[1] The states, in a very short timeframe, have implemented those revisions. In fact, 10 states completed their revisions by year end 1988.[2] Proposals that by the end of September 1989 all states will have the necessary revisions in place.

The states which have completed their revisions are now submitting their Medicare supplement programs to the Supplemental Health Insurance Panel, which was established under the original Baucus amendment, for certification.[3] As of June

1989, 7 states were approved by the Panel.[4] Twenty-one states have been "conditionally approved," which means that the state is in full compliance, but approval is conditional pending final action by the state.[5] The remaining states' proposals are in various stages of review by the Health Care Financing Administration staff. The NAIC expects that all states will complete their revisions by September 20, 1989, (one year after NAIC adoption) and will either become or will remain certified:

II. MEDICARE SUPPLEMENT PREMIUMS

Mr. Chairman, many have inquired why Medicare supplement insurance premiums appear to be increasing after passage of the Catastrophic Act. Because the Catastrophic Act increased Medicare benefits for it beneficiaries, it was certain that there would be fewer. Medicare supplement insurance benefits to insure and as a result, it was thought that refunds or credits would be due to existing policyholders. As it turns out, however, not all existing policyholders are receiving refunds. In fact, it has come as a surprise to some that the premiums are actually increasing.

There is a wide variance in the premiums on these existing policies (those in existence on January 1, 1989). The states report that the Catastrophic Act, by itself, has generally caused premiums to decrease slightly because it required insurers to eliminate benefits now covered under the Medicare program. However, other factors, such as the timing of the premium adjustment, the increase in utilization and higher prices for medical services, the length of time which has elapsed between premium increases, recent loss ratio performance, and addition of new minimum benefits have all contributed to a net increase in premiums on the existing policies.

For the year 1989, the changes in the Medicare program occasioned by the Catastrophic Act affect Part A (hospital) services only: inpatient hospital services, skilled nursing facility (SNF) care, and blood. In 1989, the Medicare program was expanded to cover an unlimited number of days in the hospital (after a $560 deductible). Medicare was also expanded to eliminate the prior hospitalization requirement for SNF care. Now, Medicare covers 100 percent of costs after the first 8 days of SNF care (up to 150 days).

Therefore, only these items which relate to Part A of the Medicare program were eliminated from the existing policies effective January 1, 1989. Because these new Medicare benefits in Part A are not that extensive, refunds may be slight or may not occur at all.

Premium adjustment information has been filed with the departments and states are now examining or approving (if a state has prior approval authority) rate increases or decreases on the policies which have previously been approved and were in the hands of policyholders on January 1, 1989.

Departments are also examining the brand new policy filings to which the NAIC's revised minimum benefit standards apply, once adopted. The significance of the revised benefit standards is that they require insurers to include certain additional benefits in any new policies. The additional benefits which are required in 1989 are:

1. Either all or none of the Medicare Part A deductible ($560),
2. Coverage for the first 8 days of skilled nursing facility (SNF) care ($25.50 per day=$204), and
3. Coverage for the cost of the first 3 pints of blood (difficult to estimate, but approximately $50 per pint=$150).

It is these new benefits that are taken into account when reviewing premiums for the Medicare supplement policies offered in 1989. However, it must be noted that some companies offered some of the above items, for example, the deductible, even though such items were not required prior to 1989.

In summary, existing policyholders may not receive refunds as a result of the Medicare Catastrophic Act. Further, the brand new policies containing the new minimum benefits will likely cost more than the existing policies.

III. NAIC ACTIVITY

Because of the concern of the state regulators about the continuing abuses in connection with the sale of Medicare supplement insurance, the NAIC is moving to strengthen state prohibitions against agent and company abuse. A draft of "consumer protection" amendments to the NAIC model act and model regulation has been distributed to regulators, industry, trade organizations and consumer organizations for comment. A public hearing on the proposed amendments is scheduled for Friday, July 21, in Washington, D.C., at the Hall of States. We invite your attendance and participation. I must emphasize that the amendments are proposed, and at this time, have not been adopted by the NAIC as a whole. As you may know, the

NAIC has previously stated to the United States House of Representatives that it does not oppose strengthening of the Baucus criminal penalties, which we believe are in need of revision.

The proposed amendments focus on both agent and company abuses. The proposal requires agents to adhere to a "suitability" requirement which would obligate agents to inquire when selling policies about a prospective customer's income and the customer's need for additional insurance. The proposal requires a level commission structure for agents. Both of these measures are designed to alleviate the "twisting" or "churning" from one policy to another.

The proposed amendments also concentrate on company abuse by requiring companies to report multiple policies held by individuals. In addition, companies would be required to disclose the premium structure for each component of the policy to assist consumers in making an informed purchase.

The amendments also set forth additional penalties, including a requirement that premiums are to be returned to a policyholder, retroactively, in the event of a violation.

In addition to the consumer protection amendments, the NAIC is examining the effectiveness of its revised loss ratio reporting form and recommends an adjustment of the filing deadline from June 30 to March 1 to coincide with the filing deadline of the annual financial statements.

Lastly, the NAIC is currently working with the Health Care Financing Administration to revise the *Guide to Health Insurance for People With Medicare* for 1990. We have made available to the states a consumer education video and the states are reporting that the Medicare supplement video is a helpful tool to use in their consumer education programs.[6] I believe the NAIC sent all members of Congress information on the video, as well.

Mr. Chairman, this concludes our prepared remarks. If you have any questions, I would be happy to answer them.

FOOTNOTES

1. The NAIC held a special plenary session to adopt these revisions on September 20, 1988. The NAIC revised its **Medicare Supplement Insurance Minimum Standards Model Act** and its **Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act.**

2. Kansas, Massachusetts, Mississippi, Nebraska, New Mexico, Ohio, South Dakota, Texas, Washington and Wisconsin.

3. The Supplemental Health Insurance Panel (SHIP) consists of the designee of the Secretary of Health and Human Services, Ms. Barbara Gagel, chair, and 4 insurance regulators: Director John Washburn (Illinois), Commissioner Roxani Gillespie (California) Commissioner David Levinson (Delaware) and Commissioner Andrea "Andy" Bennett (Montana).

4. Arkansas, Iowa, Kansas, Nebraska, Nevada, New Mexico and Washington State.

5. Arizona, California, District of Columbia, Florida, Idaho, Illinois, Indiana, Louisiana, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia and Wyoming.

6. The 10-minute videotape, entitled **Understanding Insurance to Supplement Medicare,** No. 124174, can be obtained on a free-loan basis by calling Modern Talking Picture Service, Inc., 1-800-243-6877.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS,
September 29, 1989.

MS. LAURA WILCOX,
Hearing Administrator,
U.S. Senate,
Committee on Finance,
Washington, DC

Dear Ms. Wilcox: This is in response to Senator Bentsen's questions regarding the testimony of the National Association of Insurance Commissioners at the July 11 hearing on catastrophic coverage.

Queston. In those states where new standards have not yet gone into effect, do you anticipate timely implementation, or is there some controversy in these remaining states?

Answer. The NAIC does anticipate timely implementation of the new standards. As far as we are aware, there is no controversy over the prohibition against duplicating benefits already provided under Medicare. As of this date, all states have submitted their revisions to the Health Care Financing Administration for review.

Question. What led the Commissioners to believe that revisions [to the Baucus criminal penalties] may be necessary, and what types of revisions should the Committee consider?

Answer. During the revision of the *Guide to Health Insurance for People with Medicare,* which the NAIC and HCFA conducted jointly late last year: we learned that the Baucus criminal penalties provision has rarely been used. In fact, it is our understanding that only twice has the section been invoked, and without success.

The ineffectiveness of the criminal penalty section could be improved by modifying the "coordination of benefits" paragraph which reads:

> For purposes of this paragraph, benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual, shall not be considered as duplicative.

In other words, this paragraph says that as long as both policies at issue will pay benefits, the sale of both policies to an individual does not constitute duplication. The NAIC is recommending to its members in September that the sale of more than one Medicare supplement policy is excessive coverage, except where the additional coverage, when combined with basic medical expense coverage, results in no more than 100% of the individual's actual medical expenses. "Basic medical expense" does not include hospital indemnity or limited benefit policies.

I hope that this information will assist the Committee in its deliberations. Please contact me if you desire further material or information.

Sincerely,

EARL R. POMEROY, *NAIC Vice President.*

PREPARED STATEMENT OF SENATOR LARRY PRESSLER

I want to thank our distinguished colleague, Senator Bentsen, for holding this hearing to discuss the provisions of the Catastrophic Coverage Act. This legislation, more than any other in recent times, has caused older people in South Dakota a great deal of frustration. I have heard from thousands of senior citizens about this situation through letters and meetings conducted in my state. What I hear is that senior citizens are upset. In fact, they are downright mad.

Recently, I completed a survey of South Dakota senior citizens. Greater than 50 percent would like the benefits repealed or implementation delayed. The second highest percentage want to make participation in the program voluntary. They want a separate category for the catastrophic program. The elderly do not want the catastrophic provision voluntary under Part B. Part B of Medicare should be left as it now stands. The benefit of greatest value to senior citizens is perceived to be the "spousal impoverishment" provisions.

Senior citizens view the current premium as far too excessive for the benefits provided. The cost of the catastrophic program is a burden paid by too few people. If coverage remains the same, then a different method of financing must be devised.

The provisions of the catastrophic program already are available to many senior citizens through their supplemental insurance programs. Why duplicate what people can already obtain, for less money, through the private sector? How can we justify the excessive price tag on benefits so few people will ever enjoy?

For example, how many people will use 365 days of hospital care in a year? In order to remain in a hospital and collect Medicare reimbursement, the individual must show continuous progress. Someone who requires 365 days of care does not demonstrate a steady recovery.

Second, the nursing home provisions available through the catastrophic program are limited. Nursing home must offer skilled care and be certified by Medicare. How many homes meet those qualification? In South Dakota, I am aware of only four homes in the entire state that accept Medicare eligible residents. I am confident that other states could identify a similar situation.

If we really want to help people who need long-term care, then lets talk about long-term care insurance. There is a definite need to finance extended care. Many South Dakotans who have communicated with me have mentioned this need.

Home care, hospice care and access to ambulatory care services are valued by senior citizens. Today's seniors are very concerned about the high cost of a visit to a doctor's office. They are horrified by the inadequate reimbursement to physicians in rural states. Why do senior citizens in South Dakota pay the same for Medicare Part B, yet the physicians who treat them are not paid the same as their urban

counterparts who offer the same procedures? Why should our rural elderly suffer because physicians no longer can afford to practice in rural communities such as Ipswich, South Dakota or Lake Preston, South Dakota?

The people I represent in rural South Dakota are asking for the repeal of the Catastrophic Coverage Act. If it is not repealed, they want it delayed. They want the surtax eliminated and the program made voluntary. Like many other elderly throughout the United States, South Dakotans want action before it is too late. I urge you to listen to the people affected by the catastrophic program

Thank you very much for this opportunity to speak on behalf of many thousands of elderly South Dakotans. I offer you my support in making the necessary changes in this program.

CATASTROPHIC COVERAGE ACT OF 1988

1. LISTED BELOW ARE SOME OF THE OPTIONS SENATOR PRESSLER COULD CONSIDER. INDICATE THOSE YOU SUPPORT.

27	Keep the law as it is.
173	Delay the catastrophic benefits and premiums until Congress can review the program.
66	Repeal all of the benefits and all of the premiums.
41	Keep the current benefits and current financing, but allow people who do not want Part B coverage in Medicare the option of dropping out of the program.
36	Cut benefits such as respite care, prescription drug coverage and limit expanded home-health care. New costs would be covered by a flat premium in the Part B program. Those who do not want the coverage could drop Part B.
35	Keep the current benefits and current financing, but allow people to drop out of the program if they do not want Part B cover in Medicare.
90	Keep the current benefits and add long-term health care for children as well as seniors, limit doctor charges to what Medicare allows, cut the catastrophic premium and surtax in half and extend the Medicare payroll tax to earnings over $48,000, thus affecting only the top five percent of wage earners.

2. CATASTROPHIC HEALTH INSURANCE CAN OFFER MANY BENEFITS. ON THE LIST OF BENEFITS BELOW, PLEASE PLACE A CHECK MARK IN FRONT OF THOSE YOU FEEL SHOULD BE INCLUDED AND THAT YOU WOULD BE WILLING TO PAY FOR.

99	All hospital costs, except for a $560 deductive.
85	Expanded home health care.
84	Expanded skilled nursing home benefits.
99	Long-term care insurance.
76	Coverage for most prescription drug costs in excess of $600 annually.
113	Help for my spouse if I become a Medicaid patient in a nursing home, to protect our income and assets, rather than spending everything on care.
74	Cap payments for physician services at approximately $1,400 per year.

3. OTHER COMMENTS: Below are a list of comments that tended to be very popular among several of the respondents.

If coverage remains the same, then every one should pay in the same manner as social security.

The premium is too high for the benefits available. The cost of the act is a burden paid by too few people. The premium of $2100 is far too high for people who have carefully planned for their retirement.

The most important item is expanded skilled nursing home benefits.

Cap what doctors can charge for their services. There is too large a difference between what is billed by the doctor and what is approved by Medicare.

Catastrophic health insurance is way too high. This insurance needs to be dropped.

The present law is difficult to understand. It does not seem to be fair in its proposed financing.

As the catastrophic bill is now formulated, it seems the middle-income class will have the brunt of the financing while receiving only a small part of the benefits.

The method of financing this program is flawed and needs to be rethought.

The U.S. needs to check into a socialized medical program such as those in Great Britain and Canada. We have needed this for years.

Prepared Statement of Senator David Pryor

Mr. Chairman, I commend you for holding this hearing today on the duplication of benefits and the advisability of making the Medicare Catastrophic Coverage Act a more optional benefit. It is my hope and expectation that the testimony given today will help us develop approaches that will address these and other important concerns that have been raised about the Act.

One concern of interest to all of us on the Finance Committee is the cost of the new program and the question of whether we can reduce the premiums of Medicare beneficiaries. Mr. Chairman, it is my understanding that the Congressional Budget Office has recently re-estimated the cost of the new outpatient drug benefit and it is significantly greater than they had originally projected. Moreover, I have been informed that the primary reasons for the dramatic change in these estimates is the ever-increasing prices of prescription drugs and the proliferation of new prescription drugs in the marketplace.

These new estimates are a bitter pill to swallow for Medicare beneficiaries who had hoped that there would be sufficient revenue to reduce the premiums for the catastrophic coverage. It is also bad news for those of us that had hoped to find ways to lessen the burden of the supplemental premiums for our elderly and disabled constituents.

I am deeply concerned about prescription drug prices and am committed to finding ways to control inflation in this area. Next Tuesday, I will chair an Aging Committee hearing that will scrutinize both the value and the market prices paid for prescription drugs. It is my intention to use this and subsequent Aging Committee hearings on this issue to begin to develop cost-savings proposals for consideration by the Finance Committee.

We face and must address many critical issues related to the Medicare Catastrophic Coverage Act. I am pleased to join you, Mr. Chairman, in this important effort. I believe that the testimony from our witnesses today will help us to strengthen this legislation.

Prepared Statement of Alan Reuther

Mr. Chairman, my name is Alan Reuther. I am an Associate General Counsel of the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW). The UAW represents one million active and 500,000 retired workers and their families. We are pleased to have this opportunity to share with you our views on various issues relating to duplication of health care coverage under the Medicare Catastrophic Protection Act.

In earlier testimony before this Committee, we set forth our overall views concerning the Medicare Catastrophic Protection Act. As indicated in that testimony, we oppose the various proposals which have been offered to repeal the Act, to impose a moratorium on further implementation, or to cut-back on the benefits provided under the program. The benefits of the catastrophic program are extremely valuable and should be preserved. But the UAW believes that the manner in which those benefits are financed should be changed. We strongly support the legislation introduced by Senators Harkin and Levin (S. 1125), which would repeal the surtax on the elderly, replace it with general revenues and raise those general revenues by extending the existing 33 percent tax bracket to very wealthy taxpayers.

In addition to these overall concerns, the UAW is troubled by the inequities which have been created by the Medicare Catastrophic Protection Act for senior citizens who previously had catastrophic health insurance coverage provided by their former employer. This testimony will discuss problems associated with such duplicative coverage and possible approaches for dealing with the problems.

DUPICATIVE COVERAGE

Prior to enactment of the Medicare Catastrophic Protection Act, some employers provided their retirees with health insurance coverage comparable to the benefits provided under the catastrophic program. The Federal Government provided such coverage to retired Federal employees through the Federal Employees Health Benefits Program. Some state and local governments and many private employers also provided similar coverage to retired employees.

The Department of Labor has estimated that 4.3 million retirees and dependents age 65 or older were covered by employer-sponsored retiree health insurance programs in 1983. The Employee Benefits Research Institute has estimated that 7.6 million such persons were covered in 1984. These estimates translate into roughly 16 and 27 percent of the age 65 and over population, respectively. Intermediate estimates indicate that nearly 25 percent of the age 65 and over population was covered under employer-sponsored retiree health insurance programs in 1983.[1]

The benefits provided under these plans varied from employer to employer. In some cases, the programs provided virtually all of the benefits covered under the Medicare Catastrophic Protection Act. In other cases the benefits were more limited. The programs also differed in the extent to which the coverage was paid for by the employer. Some programs were paid for entirely by the employer, while other programs required the retiree to pay a portion of the premiums.

The UAW's collective bargaining agreements with the major automobile, aerospace and agricultural implement companies provide comprehensive health insurance coverage to retired employees and their families. This health insurance coverage is paid for entirely by the employer. It encompasses all of the benefits provided under the Medicare Catastrophic Protection Act, as well as certain additional benefits (such as vision and dental care). For those retirees and dependents who are over the age of 65 and are enrolled in Medicare, the employer-sponsored retiree health insurance programs provide supplementary, "wrap-around" coverage, filling in whatever benefits are not covered under Medicare.

The enactment of the Catastrophic Act has resulted in a huge windfall for employers which maintained retiree health insurance programs for post-65 retirees and their families. Because the catastrophic program expanded the benefits covered under Medicare, it correspondingly reduced the benefits which have to be covered under these employer-sponsored retiree health insurance programs.

The General Accounting Off ice has estimated that the Medicare Catastrophic Protection Act will reduce employers' health care costs for retirees age 65 and over by 5 percent in 1989, by 15 percent in 1990, and by 19 percent when fully phased in. The Medicare catastrophic program has also reduced the present value of retiree health insurance benefits which have been accrued by workers and retirees by $30 billion, representing a 13 percent decrease in the total accrued retiree health insurance liabilities.[2]

At the same time that it was providing an economic windfall to many employers, the Catastrophic Act also imposed significant new costs on senior citizens. In addition to a new flat premium, which will rise from $4 per month in 1989 to $10.20 per month in 1993, the Medicare catastrophic program also levied a new supplemental, income-related premium on the elderly. This surtax will amount to 15 percent of senior citizens' Federal income tax liability in 1989, and will rise to 28 percent of Federal income tax liability in 1993. The total amount of the surtax is capped at $800 per beneficiary in 1989 (this cap rises to $1,050 in 1993). Through the combination of the flat premium and the supplemental, income-related premium, the elderly are required to pay for the entire cost of the catastrophic benefits.

In light of these two factors, it is hardly surprising that the Medicare Catastrophic Protection Act has evoked such a negative response from senior citizens. The net result of the program is to provide an economic windfall for many employers (by reducing costs under their retiree health insurance programs), and to shift the cost of paying for catastrophic benefits from these employers directly to the elderly. Accordingly, many retirees covered under employer-sponsored retiree health insurance programs—including many UAW retirees—are actually worse off as a result of the catastrophic program. Prior to the enactment of the Medicare Catastrophic Protection Act, these retirees received catastrophic health insurance benefits under their employer-sponsored program, with all or part of the cost being paid for by the employer. With the adoption of the Medicare catastrophic program, however, the retirees are now being required to pay substantial premiums for these same benefits.

The UAW does not believe that the Members of this Committee or the Congress intended this result. The purpose of the catastrophic legislation was to expand the protections afforded to the elderly under Medicare, to ensure that senior citizens are not suddenly bankrupted by catastrophic illnesses. It was not intended to provide companies with a windfall, or to shift the costs of providing catastrophic health insurance coverage from employers to senior citizens.

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[1] Joint Committee on Taxation, *Present Law and Issues Relating To Employer-Provided Retiree Health Insurance,* (JCS–15–89), June 12, 1989.

[2] *See* Statement of Lawrence H. Thompson, Assistant Comptroller General, Human sources Division, General Accounting Office, before the Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, June 14, 1989.

MAINTENANCE-OF-EFFORT

In an effort to address the problems created by duplicative health insurance coverage provide under employer-sponsored retiree health insurance plans, Senator Riegle offered an amendment when the catastrophic legislation was being considered on the Senate floor which established a so-called "maintenance-of-effort" requirement. The amendment, which was accepted by Chairman Bentsen, was approved by the Senate without opposition. The House subsequently agreed to this provision in conference, with some modifications.

The maintenance-of-effort provision in the Medicare Catastrophic Protection Act basically requires any employer (including state and local governments) that was previously providing to their retirees 50 percent or more of the benefits included under the Medicare catastrophic program (excluding prescription drugs) to provide either additional benefits or a cash rebate to the retirees equal to the value of the duplicative health care benefits. This obligation only applies for one year with respect to the improvements under Medicare Part A, and one year with respect to the improvements under Medicare Part B, or until the end of an existing collective bargaining agreement (if later). In determining the value of the additional benefits or cash rebate which must be provided to retirees, employers are given the option of using national average actuarial values calculated by the Health Care Financing Administration (HCFA) or of calculating the actual value of their own duplicative benefits.

The UAW commends Chairman Bentsen and Senator Riegle for their leadership in securing usage of the maintenance-of-effort provision. Although this provision did not go as far as we would have liked, at least it began to address the problems created by duplicative health insurance coverage. On a temporary basis, it seeks to prevent employers from reaping an economic windfall and shifting the casts of providing catastrophic benefits to retirees.

The UAW is currently in the process of negotiating with the major automobile, aerospace and agricultural implement companies over the implementation of the maintenance-of-effort provision. Our experience indicates that many employers will elect to pay a cash rebate, instead of adding new benefits. Most employers are also electing to use the national average actuarial values calculated by HCFA, rather than calculating the actual value of their own duplicative benefits. HCFA has calculated that the national average actuarial value of the Part A improvements is $65 in 1989. HCFA has also estimated that the national average actuarial value of the Part A and Part B improvements (excluding prescription drugs) will be $72 and $94 respectively in 196)0. This means that each retiree will receive a cash rebate of $65 in 1989, and approximately $166 in 1990. In some cases the rebates are being paid in monthly installments. In other cases they will be paid as a lump sum at the end of the year.

Although these maintenance-of-effort payments will provide some relief to UAW retirees and other senior citizens, they do not solve all of the problems created by duplicative health care coverage under employer-sponsored retiree health insurance programs. To begin with, the maintenance-of-effort provision is only temporary. Once it expires, the cost of providing the catastrophic benefits will still shifted from employers to retirees. Furthermore, there will still be many cases where the basic and supplemental premiums paid by retirees under the Medicare catastrophic program will exceed the value of any rebate or additional benefits paid by their employer under the maintenance-of-effort provision. Thus, these retirees will still worse off than they were before enactment of the catastrophic program.

To address these concerns, the UAW urges this Committee to consider a number of improvements to the maintenance-of-effort provision. First, the maintenance-of-effort obligation should be made permanent for all persons who have retired. Many courts have held that retiree health insurance is a vested, lifetime benefit which may not be reduced or terminated once a worker retirees, *see, e.g. UAW* v. *Yard-Man,* 716 F.2d 1476 (6th Cir. 1983), *cert. denied* 104 S. Ct. 1002 (1984); *UAW* v. *Cadillac Malleable Iron Co., Inc.* 728 F.2d 807 (6th Cir. 1984); *Local 150-A, UFCW* v. *Dubuque Packing,* 756 F.2d 66 (8th Cir. 1985).

Second, the maintenance-of-effort obligation should apply to all individuals covered under employer-sponsored retiree health plans which provide duplicative coverage, not simply individuals who retired prior to the date the Medicare catastrophic program was enacted. So long as an employer has promised to provide the duplicative health benefits to the individual, the employer should be subject to the maintenance-of-effort obligation, regardless of whether the person retired before or after the date the catastrophic program was enacted.

Third, the maintenance-of-effort obligation should apply to all of the benefits provided under an employer-sponsored retired health plan which duplicate *any* of the benefits provided under the Medicare Catastrophic Protection Act. This includes benefits under the new prescription drug program, as well as the improvements under Medicare Part A and Part B. Moreover, the maintenance-of-effort obligation should be cumulative. For example, in calendar year 1990 any employer subject to the provision should required to a provide additional benefits or a cash rebate equal in value to all duplicative benefits under bath Medicare Part A and Part B, not simply those covered under Medicare Part B.

Fourth, the threshold for applying the maintenance-of-effort obligation should lowered significantly. Currently the maintenance-of-effort provision only applies to employers which previously provided 50 percent or more of the catastrophic benefits. Although there may be justification for excluding employers who only provided a *de minimus* portion of the catastrophic benefits, we believe the 50 percent threshold is too high.

Fifth, the law should be amended to make it clear that maintenance-of-effort rebates are not subject to Federal income and FICA taxes. Maintenance-of-effort payments are simply a substitute for retiree health benefits which were formerly provided by the employer. Retiree health benefits are considered deferred compensation, and thus are not subject to FICA taxes. Furthermore, retiree health benefits are also exempt from Federal income tax, just like health benefits provided to active workers. Accordingly, the UAW believes that maintenance-of-effort payments should be treated in a similar manner.

In addition to the foregoing improvements, we urge this Committee to explore the possibility of allowing employers, in lieu of the maintenance-of-effort obligation, to purchase catastrophic coverage from Medicare on behalf of their retirees. This could be accomplished by loving employers pay to Medicare on behalf of each retiree an amount equal to the actuarial value of the catastrophic benefits for that year. If an employer chooses this Medicare "buy-in" option, the retirees would be exempt from the flat premium and surtax levied under the catastrophic program.

In order for this type of approach to be workable, employers would have to purchase the catastrophic coverage on behalf of *all* of their retirees. They could not be allowed to discriminate in favor of certain retirees (such as highly compensated retired executives). In addition, it might be necessary to establish some minimum size for employers, in order to prevent abuses.

With appropriate safeguards like these, we believe that this Medicare "by-in" approach could be quite feasible. We believe it would be revenue neutral. Although the flat premiums and surtax paid by some retirees would exceed the actuarial value of the catastrophic benefits, for other retirees the premiums and surtax would be less than the actuarial value of the catastrophic benefits. When viewed in the aggregate, the premiums and surtax paid by all of the retirees from any large employer should approximate the actuarial value of the catastrophic benefits.

This Medicare buy-in proposal would not entail increased costs for employers which were previously providing the catastrophic benefits under employer-sponsored retiree health plans. Prior to passage of the Medicare catastrophic program, these employers either purchased the catastrophic coverage from private insurance carriers or else provided these benefits on a self-insured basis. Under this Medicare "buy-in" proposal they would simply be purchasing the coverage from Medicare. It would be the same as if the employers simply shifted insurance carriers. Furthermore, the Medicare buy-in approach would cost the same as the existing maintenance-of-effort obligation.

However, from the point of view of the retirees, the Medicare buy-in proposal would be preferable to the existing maintenance-of-effort provision. The retirees would be returned to a situation comparable to what they had prior to the passage of the Medicare catastrophic program. They would still he receiving the same catastrophic benefits. And the cost would still be paid by their employer. Thus, the retirees would effectively be made whole.

The UAW recognizes that there are many details which would have to be worked out in order to implement this type of Medicare "buy-in" proposal. We are prepared to work with you Mr. Chairman, and the other Members of this Committee to develop such a proposal.

MAKING CATASTROPHIC VOLUNTARY

There has been considerable discussion about proposals to make the Medicare catastrophic program "voluntary." On the surface, these proposals may appear to be an attractive way of dealing with the problems created by duplicative health care coverage. Rut when such proposals are examined in more detail, we believe that they create more problems than they would resolve. Accordingly, the UAW strongly opposes this idea.

One proposal would allow retirees to opt out of the catastrophic program, but would still permit them to enroll in the Medicare Part B program. The problem with this proposal is that it would almost certainly result in a large revenue loss to the Federal government, thereby undermining the solvency of the catastrophic program.

The guiding principle underlying the financing of the Medicare catastrophic program is that the elderly have to pay for the entire cost of the catastrophic benefits. The cost of the catastrophic befits is subsidized for the approximately 60 percent of Medicare beneficiaries who only pay the flat premium. As a result, the remaining 40 percent of Medicare beneficiaries who are subjected to the supplemental, income-related premium are forced to pay amounts in excess of the value of the catastrophic benefits. If the Medicare catastrophic program were made voluntary, standing by itself, most of these individuals would decide to opt out of the program. In the end, the catastrophic program would be left covering only lower-income senior citizens. The Federal government would then be faced with the difficult choice of increasing premiums for this vulnerable group or simply accepting a substantial loss of revenues under the program.

Another proposal would allow retirees to opt out of the catastrophic program only if they also decide to opt out of the Medicare Part B program. This approach was incorporated into the version of the catastrophic legislation that originally passed the Senate. Because of the appropriate general revenue support for the Medicare Part B program, when the catastrophic and Part B programs are considered together they are still a good deal for the elderly, including those who are subjected to the maximum surtax under the catastrophic program. Thus, it is assumed that most senior citizens would still decide to enroll in the catastrophic program, in order to retain their coverage under Medicare Part B. Accordingly, this type of approach might not result in the same loss of revenue as the proposal referred to above.

We still have serious reservations about the assumption underlying this proposal. We believe that the supplemental, income-related premium has generated such a negative reaction that many senior citizens might decide to opt out of both Medicare Part B and the catastrophic program, even if it was not in their financial interest to do so. The experience with private Medigap insurance policies has demonstrated that many senior citizens have den encouraged to purchase unnecessary or duplicative coverage by unscrupulous insurance agents. We are concerned that the private insurance industry might try to stimulate an exodus from the Medicare Part B and catastrophic programs by feeding on the fears of senior citizens concerning the new surtax. We are also concerned that there might be a significant problem of adverse selection. Middle and upper income seniors who are subjected to a hefty surtax, but who are in good health, might able to purchase health care coverage more cheaply on their own.

Most importantly, senior citizens who are covered under certain employer-sponsored retiree health insurance programs could still have an incentive to opt out of both Medicare Part B and the catastrophic programs. There are some collective bargaining agreements which provide that if a retiree chooses not to enroll in Medicare Part B, the company is obligated to provide health care coverage to the retiree. Until now, most UAW retirees have voluntarily enrolled in Medicare Part B. But if enrollment in Medicare Part B was linked to enrollment in the catastrophic program, some retirees might decide that it was no longer in their interest to stay in these programs.

For all of these reasons, we are concerned that a substantial number of senior citizens might decide to opt out of both the Medicare Part B and the catastrophic programs if enrollment in the two programs were linked. In the long run, this could undermine the social insurance nature of the Medicare program. The UAW has long taken the position that social insurance programs like Social Security and Medicare should provide coverage to all potential beneficiaries. We continue to believe that all senior citizens ought to be covered under both the Medicare Part B and the catastrophic programs.

Even if these concerns proved to be unfounded, and most senior citizens decided to enroll in both the Medicare Part B and the catastrophic programs, we still could not support this proposal. This is because it does not do anything to address the fundamental inequities associated with the financing of the Medicare catastrophic program. Indeed, it is really a misnomer to characterize this proposal as making the catastrophic program "voluntary." Although senior citizens would have the right to opt out of the catastrophic program under this proposal, they would be subjected to an extremely heavy penalty if they chose this option—that is, they would also have to opt out of Medicare Part B and lose the subsidized coverage offered under that program. Thus, senior citizens would still effectively be compelled to enroll in the catastrophic program in order to retain their subsidized coverage under the Medicare Part B program.

An analogy may be helpful in illustrating this point. In order to expand access to health care, it has been proposed that employers should be required to provide health insurance coverage to workers and their families. One way to accomplish this would be through a direct mandate under ERISA or the Fair Labor Standards Act. Another way to do this, however, would be indirectly through the tax code. Congress could impose a stiff excise tax on any employer which fails to provide such health care coverage, or it could take away certain tax subsidies which are currently available to these employers. For example, Congress could disallow deductions for various business expenses for these employers. Although technically employers would still have the option not to provide health care benefits to their workers, surely no one would characterize this as a truly "voluntary" situation. The penalty of losing the tax subsidy would be so great that it would amount to a *de facto* mandate on employers.

The same would be true for senior citizens if enrollment in the Medicare Part B and catastrophic programs were linked. Although the catastrophic program would theoretically be "voluntary," the penalty for failing to enroll in the program would be so great that it would effectively be compulsory.

Prior to the enactment of the Medicare Catastrophic Protection Act, all senior citizens had the right to enroll in the Medicare Part B program. And all senior citizens received the same subsidy under that program, since three quarters of the cost of Medicare Part B is paid for through general revenues. This was a basic entitlement available to all senior citizens.

The proposal to link enrollment in the catastrophic program with enrollment in the Medicare Part B program is simply an indirect means of reducing the subsidy under the Medicare Part B program for middle and upper income senior citizens. In the post we have consistently opposed proposals to reduce the portion of the Medicare Part B program which is subsidized through general revenues. Accordingly, we also oppose any proposal which would indirectly accomplish the same result, by linking enrollment in the Medicare Part B program with enrollment in the catastrophic program.

CONCLUSION

In conclusion, Mr. Chairman, the UAW appreciates the opportunity to present our views on the problems associated with duplicative health care coverage under the Medicare Catastrophic Protection Act. We believe that the maintenance-of-effort provision should be improved in a number of respects in order to address the inequities resulting from duplicative health care coverage. But we strongly oppose proposals to make the Medicare catastrophic program voluntary. We look forward to working with you and other Members of the Committee in seeking solutions to these difficult problems. Thank you.

PREPARED STATEMENT OF JOHN J. RHODES, III

Mr. Chairman, thank you for permitting me to appear before your Committee to discuss the burden of catastrophic health care that is weighing upon millions of American seniors.

I applaud your decision to hold these hearings and commend you for your willingness to remain favorably disposed to proposals that modify the onerous payment provisions in current law. Furthermore, I am encouraged and feel that our cause is emboldened by your recommendation to cut the supplemental premium.

I support measures that lift this tremendous burden off the shoulders of senior Americans. This includes your proposal of a substantial reduction in the supplemental premium as well as the legislation pending in both houses of Congress that would repeal the surtax and delay implementation of some of the benefits. However, these piecemeal delays and modifications, though well-intentioned, are only efforts to ameliorate the symptoms of current law. Though I support the short term reforms that ease the pain, I prefer to eliminate the cause of the pain and repudiate temporizing solutions in favor of a long-term solution.

A delay in the implementation of the benefits coupled with a delay in the imposition of the burdensome surtax would only be temporary. This would give experts the time to study the revenue implications of the existing law and reconsider if some of the benefits are in fact duplicated by private coverage or pension benefits. If and when we postpone implementation of the 1988 Act, we must decide what to do in the interim period. Continuing delays only prolong the inevitable implementation of an unacceptable act. Consequently, I have introduced legislation, H.R. 2055, that 46 of my colleagues have agreed is the ideal vehicle for substantive long-term reform.

Senior citizens who are supposed to foot the bill for the 1988 Catastrophic Act are flooding congressional offices with angry letters and phone calls that relay an unmistakably clear message: they do not want and will not use the coverage provided under the Medicare Catastrophic Act of 1988. Many of the provisions of the Act duplicate coverage that many senior Americans have through less expensive private insurance. Furthermore, the mandatory surtax unfairly penalizes Americans who have been prudent in their savings.

However, as we all know, even those who have been responsible in their finances often find themselves financially devastated by a debilitating illness. By repealing the costly and misplaced provisions of the 1988 Act and by retaining those provisions which address the catastrophic health care needs of senior Americans, my bill eliminates the need for the surtax as a financing mechanism. My bill will eliminate the surtax, appearing in the 1988 Act under the guise of a "supplemental premium," and will return to the traditional financing method, relating cost paid to benefits received through optional Medicare Part B premiums. Consequently, Medicare will become the voluntary program it once was, no longer compelling seniors to pay for benefits they already enjoy.

Unlike the current law, my bill, The Medicare Catastrophic Coverage Reform Act of 1989, addresses long-term care by stimulating private sector development of long-term care insurance through tax incentives. Identified as the most prevalent concern amongst senior groups today, provisions encouraging long-term care constitute a significant portion of my proposed legislation. My legislation allows for the tax-free roll over of funds from a life insurance policy and/or from an Individual Retirement Account (IRA) for the purchase of long-term care insurance. Additionally, it allows employers the same tax deductions for long-term care insurance as are currently used for health and life insurance benefits.

My bill also provides a prescription drug benefit for only those elderly who truly need it. Currently, it is estimated that only 17 percent of senior Americans are expected to incur prescription drug benefits in excess of the $600 deductible dictated in the law passed last year. The Reform Act targets the prescription drug benefit to those who most in need: Americans 65 or older who live at or below 150 percent of the poverty rate.

Our Catastrophic Coverage Reform Act of 1989 is a fair and equitable answer to the needs of millions of Americans. Moreover, it is the right thing to do.

Mr. Chairman, thank you again for allowing me to appear before your Committee to discuss this matter of monumental importance. I am encouraged by your support of modification proposals and look forward to working with you and your colleagues in the Senate to effect a change in the Medicare Catastrophic Coverage Act of 1988.

Prepared Statement of Senator William V. Roth, Jr.

It is a well-known fact that many of our elderly live on fixed incomes. With the ever rising cost of living, even seniors who have worked all their lives can suffer true financial hardship if there is an unexpected need for extended hospitalization. Protecting Seniors from these costs is a goal many thought was achieved last Congress with enactment of the Medicare Catastrophic Coverage Act of 1988. However, in my view, we have yet to achieve this goal.

Before Catastrophic Insurance was enacted, many private and public sector retirees were already provided with retirement health plans, most of which contained some form of catastrophic protection. In addition, 70% of all Medicare beneficiaries subscribed to medigap insurance policies. Similar to private sector retirees, Federal pensioners are provided with catastrophic protection in their health plans. In fact, the Blue Cross/Blue Shield plan offered as one of the many plans available to Federal Retirees, includes a catastrophic protection benefit. Therefore, the new law boils down to many seniors being hit with a "double whammy" of having to pay twice for benefits they already had.

There are many inherent inequities in the "Catastrophic" law. We have the situation where retirees MUST pay stiff premiums for benefits that duplicate those provided to them in their retirement health package.

I think it is important to point out that "Catastrophic" also penalizes the working elderly. Seniors eligible for Medicare Part A, who work for an employer with at least 20 employees, and who are enrolled in the employer's health care program, are exempted from any late penalty for enrolling in Medicare Part B. Yet, even though these working Seniors are exempted from one premium without any penalty and do not receive any benefits under Part B—they MUST still pay the annual supplemental premium which is required of all "Medicare ELIGIBLE" individuals.

I thank the Chairman for this continued consideration of Catastrophic Insurance in holding today's hearing. I look forward to the testimony, and the opportunity to address the concerns of Medicare beneficiaries.

PREPARED STATEMENT OF GAIL SHEARER

Mr. Chairman and members of the Committee, Consumers Union* appreciates the opportunity to present our views on the issue of private health insurance to supplement Medicare ("Medigap" insurance). The Federal Government has a special obligation to monitor the performance of this market, since the design of its own Medicare program has in effect created the supplemental market, and because there is a great deal of confusion about where Medicare ends and private responsibility for health care costs begin. We urge the Congress to use the window of opportunity it now has—with the implementation of the catastrophic bill—to both critically review and improve the performance of the medigap market.

In my testimony, I plan to describe the key abuses in the medigap market and propose four recommendations for legislation to eliminate these abuses. The centerpiece of our recommendation is *standardization,* which holds the potential to dramatically improve the performance of this market. Under standardization, policy benefits could not vary from standard levels set forth in "low," "medium," and "high" policies, which would range from less comprehensive to more comprehensive. The government would establish uniform definitions for key policy terms and would restrict the variations allowed for other insurance policy provisions.

While my testimony focuses on the private medigap market, I do want to note that Consumers Union strongly opposes efforts to make catastrophic protection voluntary (either on its own or with Medicare Part B coverage). Making coverage voluntary would seriously jeopardize the financial viability of the Medicare system. It would allow the private medigap industry to select the healthy and wealthy risks, turning Medicare into a program that specializes in higher health risks and lower income senior citizens.

MARKETING ABUSES AND MARKET FAILURE

Following the enactment of the Baucus amendment in 1980, there was relatively little publicity about abuses in the medigap market. But, unfortunately, this was not because the Baucus amendment had dramatically improved the performance of the market. The June issue of Consumer Reports provides some disturbing information about marketing abuses. The article uncovered examples of agent ignorance, high-pressure marketing techniques, agent efforts to sell unnecessary policies, frivolous variation between policies, and a marketplace characterized by confusion rather than clarity. The article concludes that the Baucus amendment has not cleaned up the Medicare supplement industry. "Sales abuses still abound, misrepresentation continues unabated, and there's evidence that some policies haven't achieved the target minimum loss ratios the [amendment] requires." A copy of the article is attached to my testimony. Some of the key areas of market failure are described below:

1. *Consumer Confusion and Lack of Knowledge.* The proliferation of policies makes it virtually impossible for consumers to make an informed purchase decision. Research conducted after the enactment of the Baucus amendment shows that bene-

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* Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of *Consumer Reports,* its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports,* with approximately 4 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial, and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

ficiary knowledge of Medicare and medigap coverage is low. If consumers are misinformed about Medicare coverage, they are likely to be susceptible to sales pitches leading to more supplemental coverage than they need.[1]

2. *Duplicate Coverage/Overselling.* Some people buy more than one medigap policy, paying thousands of dollars in premiums to buy overlapping, duplicative coverage. Since companies do not tend to coordinate benefits, these consumers are able to collect benefits from all of the policies they own. The point here is that uninformed consumers, who are fearful of health care costs, waste their limited dollars by over-insuring.

A 1987 survey by the Health Insurance Association of America found that 19 percent of Medicare-eligible people surveyed owned two or more medigap policies.[2] A Health Care Financing Administration study found that 17 to 34 percent of those surveyed (depending on state) owned two or more policies.[3]

This Committee has expressed concern about a problem of duplication of coverage between Medicare and private policies. Consumers Union does not consider this to be a major problem. The Catastrophic Act and the National Association of Insurance Commissioners' Transition Rule (on Medicare Supplement Insurance) clearly prohibit such duplication. This type of duplication is easy to identify and relatively easy to police against. In contrast, duplication between various Medicare supplement insurance (and hospital indemnity and dread disease) policies is not presently against the law, is difficult to detect, and, as the figures show, is extensive. The Senate should act to simplify the private market to eliminate this type of wasteful duplication.

3. *Low-Value.* The General Accounting Office's 1986 results about loss ratios were disturbing. While the Baucus amendment established a target loss ratio of 60 percent for individual policies, the GAO found that 254 of the 398 policies (64 percent) it reviewed had loss ratios below the target. The average loss ratio for commercial medigap policies was only 60 percent.[4] The General Accounting Office's recent report on 1987 loss ratios showed little improvement; 50 of the 91 policies (55 percent) reviewed had loss ratios under 60 percent.[5]

4. *Twisting.* Twisting is the term used to describe a common agent practice of convincing a client to switch policies. Agents have an incentive to do this since many policies have front-loaded commissions. In other words, the agent earns a hefty commission for first-year premiums, and much less for policy renewals. Consumers often do not benefit from being "twisted" to a different comparable policy, and face increased costs of uncovered charges, since they face new exclusions for pre-existing conditions.

5. *Deceptive Lead Card Company Practices.* As described in Consumer Reports, lead card companies send out mailings to senior citizens, requesting that the recipient fill in and return the card enclosed in the mailing. In many cases, the mailings use names to make recipients think that the sender is a government official. Some of the names include: National Health Information Center; Consumer Referral Service Center, Medicare Division; and Senior Citizens Health Services. Some companies use mailing addresses that are post office boxes in Washington, D.C., to give the impression of a government connection.

RECOMMENDATIONS FOR CONGRESSIONAL ACTION

1. *Congress should STANDARDIZE the Medicare supplement insurance market.* Standardization of the market should be the centerpiece of regulatory reform. Under standardization, the government would establish uniform definitions for key policy terms and restrict the variations allowed for other insurance policy provisions (such as length of pre-existing condition period). In a standardized market, policy benefits could not vary from standard levels set forth in "low," "medium," and "high" policies, which would range from less comprehensive to more comprehensive. Policy standardization should be distinguished from "minimum standard" types of regulation. With minimum standards, insurers are free to offer benefits greater than the minimum standard. Under standardization, no such variation is allowed.

As part of the standardization package, there should be a prohibition of the sale of duplicative coverage. No person should own more than one Medicare supplement insurance policy.

The National Association of Insurance Commissioners (NAIC) rejected standardization and adopted a minimum standard regulatory approach to medigap in 1979.[6] The Congress endorsed the original NAIC approach in 1980 in the Baucus amendment. After nine years, we know that this approach is inadequate. It is important for Congress to look beyond the original NAIC (and Congressional) regulatory approach to the innovative work of a handful of states that have embraced the concept of standardization to the benefit of their consumers.

Wisconsin led the states into standardization in 1978 when it adopted a rule establishing four distinct categories of Medicare supplement insurance coverage. While the goal of the regulation was to limit variation between policies and to promote consumer understanding, companies gradually undercut this goal by offering optional riders that made it impossible for consumers to rationally compare policies. As a result, Wisconsin recently revised its regulation to end the variation. Policies offered for sale as of January 1, 1989 are required to offer one standard minimum benefits package, with any of six standard riders (including coverage of the Part A deductible, excess charges, and foreign travel). No other benefits can be offered.

In 1980, Massachusetts adopted a "mandatory standardization benefit" approach for regulating the medigap market. The regulation established three levels of medigap coverage. All medigap policies sold in Massachusetts are required to comply with one of the three benefit options and cannot be modified. Not only did this lead to a dramatic decrease in consumer complaints, but it also resulted in very favorable loss ratios—which measure the percent of premiums that are paid to policyholders as benefits. In 1986, the General Accounting Office reported that the most popular medigap policy (a Blue Cross/Blue Shield policy) in Massachusetts had a loss ratio of 98 percent, in a market where commercial policies averaged 60 percent and Blue Cross Blue/Shield policies overall averaged 81 percent.

Minnesota recently passed legislation changing its quasi-standardization approach (four minimum levels of coverage, which could be exceeded) to true standardization (two levels, with two optional riders, but no other benefits allowed). The state insurance department had found that the minimum benefit approach led to a proliferation of benefit choices and an inordinate amount of consumer confusion. The law also changes the commission structure to a level commission for the first four years of the policy.

The Texas Senate recently approved a bill that would standardize the medigap market in Texas, but the bill was defeated in a House committee.

Support for standardization comes from people who are deeply involved in coming to the rescue of elderly people who have been victims of medigap abuses. At recent hearings of the Oversight Subcommittee of the House Energy and Commerce Committee, several witnesses called for standardization of the market. Don Gartner, an Assistant District Attorney for Santa Cruz County, California, whose office is litigating two civil lawsuits involving insurance and the elderly, said:

> Standardization of policies is important. California has about 200 Medicare Supplements approved for sale, with myriad ways of covering in dense language the same item. With such variation, there is little competition on price or quality of product. A consumer, old or young, cannot set two Medicare Supplement policies side-by-side and make an informed choice as to which is better or chapter. Neither, for that matter, can a District Attorney or Department of Insurance regulator readily determine that a policy duplicates an earlier one in order to decide whether to prosecute for twisting.

Emory Walton, the Criminal District Attorney for Eastland County, Texas, with twenty years experience prosecuting fraud cases, also supported standardization:

> Uniformity of Health Care Policies: Today, there are almost as many types of health care insurance policies as Carter has liver pills . . . consequently the elderly are often misled or confused, and the easy victims of abuse in health insurance sales. In the casualty insurance field, there are generally accepted automobile and homeowners' policies which provide all of the coverages normally needed and allow the insured to choose the coverages and amounts deemed appropriate. A similar type of generally accepted health insurance policy could be developed for all types of health care insurance.

2. *Congress should require that the commission structure for the sale of Medicare supplement insurance policies be level.* In order to eliminate high first year commissions, which are the driving force that leads many agents to "churn" their policyholders from one policy to another, high first year commissions (*e.g.,* 70 percent of premiums) should be banned. A level commission structure (*e.g.,* level for the first four years, decreasing in later years) should be adopted. Some states (e.g., Minnesota) have already taken this desirable step, but a national approach is desirable in order to make this policy uniform and to avoid an incentive for unscrupulous agents to move to more lucrative states.

3. *Congress should establish comprehensive counseling programs for health insurance for the elderly, and encourage states to do the same.* With virtually no addition-

al spending, Congress could broaden two counseling programs that are already in existence. The Department of Health and Human Services operates an 800 number to advise senior citizens about Medicare and the supplemental premium. In addition, the catastrophic bill establishes a three-year demonstration project to train volunteers to counsel the elderly about Medicare. Both programs should be expanded to encompass counseling on both private Medicare supplement insurance and long-term care insurance. Senior citizens are in great need of such counseling.

The Health Insurance Counseling and Advocacy Program (HICAP) in California and Senior Health Insurance Benefits Advisers (SHIBA) in some other states have been extremely effective in eliminating duplicative coverage and advising senior citizens of their coverage and their choices. Congress should encourage the states to establish their own counseling programs, possibly by establishing an information clearinghouse and through financial incentives.

4. *The sale of hospital indemnity and specified disease (e.g., cancer) insurance should be prohibited to people over 65.* Even with standardization of the Medicare supplement insurance market, the elderly could be "oversold" insurance if agents persuade them to buy hospital indemnity or specified disease policies, neither of which are considered to be "Medicare supplement insurance" policies. The catastrophic bill, which substantially lessens consumers' potential liability for hospital costs, makes hospital indemnity policies even less appropriate for people eligible for Medicare.

Both the Federal Trade Commission (FTC) staff and the General Accounting Office (GAO) have recently investigated hospital indemnity and specified disease policies and concluded that they do not meet the health insurance needs of the elderly. The FTC staff found that "neither of these policies should be considered to be a good alternative for persons seeking broad coverage of costs for health care that Medicare does not pay." The GAO reported that these policies are of limited value.[7]

5. *The sale of duplicative policies should be banned.* Many consumers buy more than one medigap policy or a combination of a medigap policy, hospital indemnity policy, and dread disease policy, with hopes of being assured of protection against uncovered health care costs. Standardization, banning hospital indemnity and dread disease policies, and counseling would go a long way toward ending the purchase of wasteful coverage. In addition, agents should be required to ask (and get responses in writing) about Medicaid eligibility and ownership of other health insurance policies. Agents should be subject to high monetary penalties for selling duplicative policies.

In conclusion, marketing abuses in the Medicare supplement insurance industry continue to victimize the country's senior citizens. Congress should enact legislation that would put an end to these abuses and make it possible for consumers to spend their health insurance dollars effectively. Consumers Union appreciates the opportunity to present our views.

ENDNOTES

1. Nelda McCall, Thomas Rice, and Judith Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," Health Services Research 20:6 (February 1986, Part I), pp. 642, 649.

2. "Medigap Insurance: The Elderly's Experience and Attitudes," Health Insurance Association of America, March 1987.

3. Report to Congress: *Study of Health Insurance Designed to Supplement Medicare and Other Limited Benefit Health Insurance Sold to Medicare Beneficiaries,* Otis R. Bowen, M.D., Secretary of Health and Human Services (February, 1987).

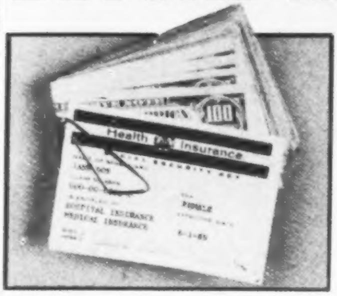
4. *Medigap Insurance,* Report to the Subcommittee on Health, Committee on Ways and Means, House of Representatives, October 1986.

5. *1987 Loss Ratios of Selected Medigap Insurance Policies,* General Accounting Office, April 1989.

6. The NAIC is presently considering making several significant changes to its model, including requiring level commissions for agents and requiring disclosure of premium pricing to facilitate comparison shopping.

7. *Marketing of Medigap, Specified disease and Hospital Indemnity Insurance to the Elderly: Report to the Committee on Energy and Commerce, U.S. House of Representatives* by the Federal Trade Commission, Bureau of Consumer Protection, September 1988, p. 128; *Health Insurance: Hospital and Specified Disease Policies are of Limited Value,* General Accounting Office, July 1988.

BEYOND MEDICARE



When President Lyndon B. Johnson signed the Medicare Act in the summer of 1965, he promised that older Americans would never be denied "the healing miracle of modern medicine," nor would "illness crush and destroy the savings they had so carefully put away." For the last quarter century the Federal government has struggled to keep that promise, spending ever-increasing sums on health care for the elderly. The Government spent only $3.2-billion on Medicare in 1967, the first year benefits were paid; by 1988 the bill came to nearly $88-billion.

For elderly patients, the cost of medical services not fully covered by Medicare has risen apace, indeed threatening to "destroy the savings they had so carefully put away."

It took 20 years from the time President Harry S. Truman proposed a Government-funded medical insurance plan to the time Congress finally passed one. During all those years, Medicare was held hostage to the charge of "socialized medicine"—the rallying cry of its political opponents, led by the American Medical Association, the American Hospital Association, and other arms [illegible]nized medicine.

To [illegible] that charge, Medicare's proponents finall[illegible] their model for paying hospitals and doctor[illegible]stem long used by Blue Cross and Blue Shield plans, insurance reimbursement systems designed by organized medicine itself. Under this "fee-for-service" model, hospitals and doctors set their own "reasonable and customary" fees, and the Blues paid them, rarely asking any questions.

The seeds of Medicare's cost explosion were sown the day Congress embraced fee-for-service reimbursement plans as the model for Medicare. For years, Medicare also asked few questions.

But in the early 1980s, Medicare stopped payment on the blank checks it had given hospitals. Instead of hospitals telling Medicare what their reasonable costs were, Medicare told hospitals what it would pay for a given diagnosis. Almost all hospital services now fall into one of 477 diagnostic-related groups (DRG's), and hospitals are reimbursed according to the diagnostic group for which a patient was admitted. A hospital usually receives a fixed dollar amount for a given diagnosis no matter how long a patient stays.

To some extent, the DRG schedule has slowed the growth in expenditures for hospital claims, since hospitals can no longer automatically pass on their costs to Medicare. But Medicare has been unable to cut costs for physicians' services to the same degree.

In the last five years, Medicare's costs for doctors alone have doubled, growing 40 percent faster than the economy as a whole. That makes the medical-insurance part of Medicare one of the Government's fastest-growing nondefense programs. Medicare coverage for doctors' bills will cost more than $30-billion this year, and spending per beneficiary is growing about 15 percent each year.

Not only have physicians proved adept at increasing their fees (see box, page 377), they may also charge Medicare patients any amount they wish above Medicare's allowable fee, up to certain Government-regulated maximums.

"Excess" physicians' fees today represent one of the biggest gaps in Medicare coverage—coverage that was never intended to pay for everything. Medicare beneficiaries also pay deductibles and coinsurance as well as excess charges. Knowing how these work is the key to understanding coverage under Medicare—and the key to choosing a supplemental insurance policy that plugs the gaps it leaves.

Beyond Medicare lies the need for supplemental insurance. The main gap to cover? Doctors' bills higher than the Medicare "allowable" charge. Plans offered by Blue Cross and Blue Shield and by the AARP fail to cover that gap well.

WHAT INSURANCE DO YOU NEED?

At the heart of Medicare's payment scheme is the "allowable charge." Medicare looks at the actual bill for a particular service and determines the allowable portion that the Government approves for coverage under the program. For hospital services, Medicare pays 100 percent of the charge; in other words, it picks up a patient's entire bill except for a deductible. For most physicians' services, it pays 80 percent; beneficiaries pay the remainder, plus any physician's fee in excess of the allowable charge. That portion of the allowable charge beneficiaries pay is called "coinsurance."

Beneficiaries must also pay deductibles, which are subtracted from the allowable charge before Medicare determines its 80 percent payment.

The particular deductibles, coinsurance, and excess charges depend on the type of service Medicare covers. Part A benefits pay for hospital and related services and are the most comprehensive. Part B benefits cover doctors' fees, various outpatient services, medical laboratory fees, ambulance services, and outpatient psychiatric care. Part B contains the most gaps for supplemental insurance to fill.

Part A: Small gaps in hospital charges

The Catastrophic Coverage Act passed by Congress last year greatly simplifed Medicare's hospital coverage. Until this year, the program required beneficiaries to pay coinsurance for certain hospital stays. Now none is required. Except for one annual deductible ($560 in 1989) paid by beneficiaries who need hospital services, Medicare picks up the entire bill, including the cost of semiprivate rooms, lab tests, X-rays, nursing services, meals, drugs provided by the hospital, medical supplies, appliances, and operating and recovery rooms.

There is an additional deductible for blood transfusions. Medicare covers the entire cost of replacing the blood (a requirement at some hospitals), but only after a patient uses three pints. Patients can either pay the replacement costs for the first three pints or arrange to have the blood replaced.

Skilled-nursing coverage. Medicare imposes strict eligibility requirements for skilled-nursing benefits. (Skilled-nursing care is defined as care prescribed by a doctor and available 24 hours a day.) It pays only if care is provided in a Medicare-approved facility; if a doctor certifies that such care is needed daily; and if the facility accepts the patient.

Patients eligible for coverage pay $25.50 each day for the first eight days of a stay. (This coinsurance payment will increase in future years.) Medicare then picks up the entire tab for such things as semiprivate rooms, meals, nursing services, medical supplies, and appliances, but only for 150 days. After that, patients who still need skilled-nursing care are on their own. Medicare pays for less than 2 percent of all nursing-home costs.

Home health-care coverage. There are also strict eligibility rules for home-health benefits. Medicare pays if care is provided by a Medicare-certified home health-care agency; if a patient requires intermittent skilled-nursing care, physical or speech therapy; if a patient is homebound; and if a doctor orders and regularly reviews such care. The benefit lasts as long as Medicare's coverage criteria are met.

Medicare pays 100 percent of the bill for occupational and physical therapists, medical supplies, medical social services, and the part-time services of home-health aides. But if a beneficiary needs medical equipment at home (oxygen or a hospital bed, for example), Medicare pays only 80 percent of the allowable charge for the equipment.

Hospice coverage. For terminally ill patients who choose care in a Medicare-certified hospice, Medicare pays all expenses for nursing and doctor services, supplies, appliances, social services, counseling, home-health and homemaker services. It also pays for pain-relief drugs, but the patient must pay 5 percent of the cost or $5, whichever is less.

This year, hospice benefits are available as long as a physician certifies the patients as terminally ill.

Psychiatric coverage. For those who need psychiatric care in a hospital, Medicare pays the entire cost less a $560 deductible. Coverage, however, is limited to 190 days of care for a patient's lifetime. After benefits run out, patients pay for additional care.

Part B: Big gaps in doctors' charges

Doctors are paid in a way that is confusing to beneficiaries and costly to the program. Here's how Medicare determines allowable charges for most Part B claims:

When a doctor submits a claim, the private insurance companies that process the claims for Medicare compare the bill submitted with the doctor's customary charge and with the prevailing charge in the community for the particular service. The lowest of the three becomes the allowable charge on which Medicare bases its payment.

Figuring the doctor's customary charge and the prevailing charge is a mind-boggling, if not a computer-boggling, exercise. For example, Empire Blue Cross and Blue Shield processes about 25 million pieces of information in its computers to determine the allowable charges for doctors in the 16 counties of New York that it serves.

Allowable charges for the same service may be different for each beneficiary, depending on the doctor's location and his or her billing practices. Not only are there regional differences, but allowable charges may vary among doctors within the same city. There's no standard or national reimbursement rate.

Under this system, it's not hard to see why Part B claims have propelled Medicare's costs into the stratosphere. Doctors continue to raise their charges for both Medicare and non-Medicare patients. Those are then cycled into both the customary and prevailing charges. And those in turn become the bases for the Medicare-allowable charge.

Medicare further gives doctors the option of accepting the allowable charge as payment in full or requiring the patient to pay the difference between the allowable and the actual charge. That gap is the excess charge.

Many doctors bill excess charges. According to the insurance companies whose policies we rate this month, such charges averaged 37 percent more than Medicare's allowable charge in late 1988. Since a patient will pay the deductible (a maximum of $75 per year), 20 percent of the allowable charge, and all of the doctor's fees in excess of the allowable charge, it's easy to see how a person might have to pay well over one-third of the medical bill out of his or her own pocket.

A doctor who agrees to accept the allowable charge all the time is called a "participating" physician. In Medicare parlance such a physician "accepts assignment." Doctors who don't are called "nonparticipating" physicians.

Only about one-third of all doctors are participating physicians, accepting assignment regularly. The rest may accept assignment only when they believe a patient cannot pay the extra charges. In effect, then, doctors are free to provide their own "means test" to patients, accepting the allowable fee for some and billing others a higher fee.

The likelihood of your doctor accepting assignment depends on where you live, the doctor's specialty, and your age. Massachusetts requires all medical doctors to accept the Medicare allowable charge as payment in full. But in Wyoming, which has no such requirement, only 18 percent of the state's physicians are participating doctors. Psychiatrists and nephrologists are more likely to accept assignment than anesthesiologists, surgeons, and general practitioners. And doctors are more apt to take assignment from patients who are

85 than from those who are 65.

About one-quarter of all Medicare Part B claims involve some excess charges, and these charges continue to mount. In 1975, excess charges cost Medicare beneficiaries $500-million. By 1987, the cost had risen to $2.7-billion, an average of $8200 for each nonparticipating medical practice.

Medicare beneficiaries pay one $75 deductible each year for all Part B services. A patient can meet the deductible requirement in one visit to a doctor or by using a combination of services. For most of the following Part B services, Medicare pays 80 percent of the allowable charge; beneficiaries pay the remaining 20 percent. There are exceptions that we note.

Doctors' fees. Part B benefits cover services furnished in a doctor's office or a patient's home and those provided to beneficiaries as hospital inpatients or outpatients. Services include anesthesia, radiology, pathology, surgery, some podiatric treatment, second-opinion consultations, dental care if it involves jaw surgery or setting broken jaw or facial bones, and one specific kind of chiropractic treatment.

In addition to the 20 percent coinsurance, beneficiaries are also responsible for any excess charges. Suppose, for example, a surgeon not taking assignment charges $2000. Medicare determines the allowable charge is $1400. The $600 difference not covered is the excess charge. The patient pays 20 percent of the allowable charge, or $280, plus the $600 excess charge, for a total of $880, assuming the deductible has been paid.

In 1990, the Catastrophic Coverage Act will limit the total amount of *allowable* charges beneficiaries are required to pay. Beneficiaries now are on the hook for unlimited

UNBUNDLED SERVICES AND "CODE CREEP"

HOW DOCTORS BOOST THE COST OF MEDICARE

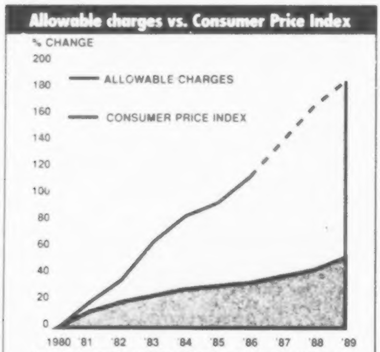
Physicians may charge Medicare patients more than the "allowable" fee, up to maximums established by Medicare. According to insurance companies whose policies we rate this month, 49 percent of providers charge the companies' policyholders more than Medicare's allowable fee.

Although Medicare has tried to control costs by setting maximums on "excess" charges, thus limiting what it will pay for certain procedures, cost increases are built into the system.

The allowable charge itself takes into account the "customary" and "prevailing" fees in the doctor's practice and in the community. But over the past 10 years, about half the increase in payments to physicians resulted not from direct fee increases but from increases in what's called "volume" and "intensity."

Volume refers to the number of services performed. Not only are doctors performing more procedures, they are now "unbundling" the fees for those services—that is, billing separately for services that were once billed, or "bundled," together. A doctor who once charged an inclusive fee for, say, an office visit and a Pap smear, might now bill separately for each. The therapeutic goal may be the same, but the total fee may be higher.

Allowable charges vs. Consumer Price Index



Annual percentage increase in Medicare's allowable charge for physicians' services per beneficiary. Includes increases due to volume and intensity as well as price (see story).

Sources: Bureau of Labor Statistics and 1988 annual report of the board of trustees of the Federal Supplementary Medical Insurance Trust Fund.

Intensity refers to shifts from less costly services to more expensive ones. It's possible to stretch out an office visit, for example, or to substitute expensive colonoscopy for a less expensive barium-enema X-ray.

The development of numerical billing codes (there are some 7300 of them, representing all physicians' services) has also made it easier for doctors to bill for a more expensive procedure. For example, a doctor can bill a new patient for an office visit using any one of five codes. There's a code for "brief service," "limited service," "intermediate service," "extended service," and "comprehensive service." There may be little difference in the time spent on a limited visit and on an intermediate one, but the intermediate visit usually costs Medicare more money. This phenomenon is called "code creep."

Some of these represent new technologies offering real value to patients, but many are merely add-ons that accomplish the same medical goal. Others represent changes in billing practices that define the same treatment to include more services. And still others may afford no effective treatment at all.

Congress is considering a fee schedule for doctors based on the relative value of the various services performed. The idea is to make fees among physician specialties more equitable and perhaps cut those fees as well, although some health-policy experts doubt such a schedule would curb increases in volume and intensity.

With the options doctors have for raising their incomes, controlling the costs of the Medicare program may be difficult, if not impossible, in a fee-for-service payment system.

But if ways are not found to stem these increases and the Treasury refuses to bear more of the burden, the explosion in Part B expenditures, whether from fee increases or from billing schemes, will ultimately shift more of the cost to patients. Consumers would thus be forced to buy more extensive supplementary insurance or risk what Medicare was intended to avoid—medical costs that destroy the savings they had so carefully put away.

amounts of coinsurance, but next year they will pay no more than $1370 for the year (including the deductible). That number will be adjusted annually.

The new law, however, does not address excess charges. Patients must still dig into their pockets to pay them, and these excess charges will not count toward the $1370 cap. Thus, excess physicians' charges are the single most important gap in Medicare, and the one most necessary to fill with supplemental insurance.

Outpatient hospital coverage. Part B benefits pay for outpatient hospital services, including those required in an emergency room or outpatient clinic. The cost of blood transfusions is also covered, but the deductible is different from the blood deductible under Part A. If a patient uses three pints and has paid the $75 yearly deductible, Medicare picks up the tab for 80 percent of the allowable charges. Patients are responsible for the 20 percent coinsurance plus replacement costs for the first three pints of blood used.

Physical, occupational therapy. For patients who need these services, Medicare requires that doctors must prescribe a treatment plan and periodically review it. If therapy is provided in an outpatient hospital facility or skilled nursing facility or by a home-health-care agency, clinic, or Medicare-approved rehabilitation agency, Medicare pays its usual 80 percent of allowable charges, and beneficiaries pay the remainder. But if patients receive such therapy from a Medicare-certified therapist who practices independently, the amount Medicare pays is limited to $400 a year.

Psychiatric coverage. Medicare pays benefits for care in either a doctor's office or outpatient hospital facility. For the facility's charge, the usual cost-sharing applies. For the doctor's charge, a special payment formula results in Medicare paying about 62 percent of the allowable charge, up to a maximum payment of $1100.

Laboratory fees. Medicare pays 100 percent of the allowable charge for clinical diagnostic tests (such as for blood and urine) performed in independent laboratories certified by Medicare. If you have tests done in a noncertified lab, you'll have to pay for them yourself. Neither laboratories nor doctors who perform clinical lab tests in their offices can bill beneficiaries for excess charges. For other diagnostic tests such as X-rays, EKGs, and tissue biopsies, Medicare's usual cost-sharing applies, and nonparticipating physicians can bill patients for amounts higher than the Medicare-allowable fee.

Ambulance services. Medicare has special rules for ambulance services. Patients must have a medical reason for needing an ambulance; the ambulance and its equipment must meet Medicare's requirements; and transporting the patient in another vehicle could endanger his or her life. If those conditions are met, Medicare pays 80 percent of the allowable charge; beneficiaries pay the remaining 20 percent.

Drugs. Currently, Medicare pays only for drugs while a beneficiary is in a hospital or skilled nursing facility; for injections in physicians' offices; and for immunosuppressive drugs a patient needs for one year following a Medicare-approved organ transplant (subject to Part B deductibles and coinsurance).

In 1990, patients who have undergone non-Medicare-approved transplants or who are in their second year following a transplant that Medicare has approved must pay a $550 deductible and 50 percent of the allowable charges for immunosupressive drugs. If a person needs home intravenous antibiotic drugs, he or she must also pay a $550 deductible plus 20 percent of the allowable charges.

In 1991, the Catastrophic Coverage Act provides coverage for all prescription drugs (including those used after organ transplants and home intravenous antibiotics), subject to a large deductible ($600) and large coinsurance amounts (50 percent for all except home intravenous antibiotics).

What's not covered

Medicare doesn't pay for in-hospital private-duty nurses or for private rooms in hospitals or skilled-nursing facilities unless such rooms are medically necessary. Neither does it pay for TVs, telephones, and other personal items.

In general, it pays only for services that are reasonable and medically necessary. A beneficiary can't submit a claim for setting a broken arm and then bill Medicare for a chest X-ray, too, unless the doctor found a clinical reason for the X-ray. Nor does the program pay for preventive care such as routine annual physicals, except for mammographic screening beginning in 1990.

With few exceptions, the program does not pay for immunizations, nor does it pay for insulin injections that patients can administer themselves. It doesn't pay for routine foot care, dental care, eyeglasses, and hearing aids and the examinations required for fitting and prescribing each. Virtually all chiropractic services and cosmetic-surgery procedures are not covered.

There are no benefits for long-term skilled care in nursing homes beyond 150 days, for custodial care that helps people cope with activities of daily living such as eating and bathing, or for meals delivered to a person's home.

If beneficiaries become sick while visiting foreign countries, they can't look to Medicare to cover their expenses. Medicare pays for treatment only in some Canadian and Mexican hospitals in some unusual situations.

Recapping the gaps

With the new catastrophic benefits, the gaps in Medicare coverage have narrowed. Except for the deductible, which rises annually, virtually all of an elderly person's hospital expenses are paid by Medicare and, after this year, the amount of coinsurance required under Part B will be limited. Were it not for excess charges, a beneficiary's hospital and medical expenses would be limited to about $2900 a year—$1370 for the Part B deductible and coinsurance, and $560 for the Part A deductible, plus any drug deductible. But if your physician bills for excess charges, as many do, or if you need a team of specialists who bill for excess charges, your out-of-pocket expenses could be far greater.

This year, a typical beneficiary will pay some $668 for Medicare coverage (including the basic and the supplemental premium), a relative bargain considering what Medicare spends—an average of $2800 a year for each beneficiary.

How much, if any, supplemental insurance to buy is a decision each Medicare beneficiary must make. The report on page 379 will help you make that decision. ■

BEYOND MEDICARE

WHICH POLICIES ARE BEST?

Medicare was never meant to cover the entire health bill for the elderly. In the early days, the gaps left by Medicare were small—and so was the premium for supplemental policies. But as health-care costs exploded, the gaps widened, and the amount spent on Medicare-supplement insurance became a major item in the budgets of the elderly.

The most generous of the policies we rated for this report would cost a senior citizen about $1000 a year. The Best Buy policies, somewhat less comprehensive, would cost about $600 a year.

Unfortunately, some elderly people are talked into buying two or more policies. Spurred by commissions as high as 70 percent of the first-year premium, agents have convinced some people to buy policies that duplicate coverage they already have and to switch frequently from one Medicare supplement to another. Some companies told us that as many as 35 percent of their policyholders drop their coverage during the first year, presumably for a competitor's brand.

There are large differences in quality among Medicare-supplement policies as well as large differences in price. Many are comprehensive, covering nearly all the remaining gaps; others cover only a few. And some policies provide far better benefits than others at a far lower premium.

Together, policies sold by Blue Cross and Blue Shield organizations and by the American Association of Retired Persons (AARP) represent more than half of all supplemental insurance sold. Yet our study found that, for the most part, the Blues and the AARP are selling relatively mediocre policies. As the Ratings on page 382 show, many of the best policies come from less-well-known companies.

Covering the hospital gaps

There's little difference among policies when it comes to filling the Part A gaps. Indeed, insurance regulators require that policies cover either all or none of the biggest gap, the $560 hospital deductible. Every policy in our study covers the deductible.

Policies must also cover the coinsurance payment of $25.50 a day for the first eight days of care in a skilled-nursing facility, but they don't have to offer coverage after the 150th day, when Medicare stops paying the bills.

Here, differences among policies emerge. Many pay nothing after 150 days; others provide coverage ranging from generous to skimpy. Colonial Penn, for example, pays 100 percent of the national average daily charges, subject to a maximum of $100,000, but Blue Cross and Blue Shield of Massachusetts pays a meager $10 a day.

Note that neither Medicare nor Medicare-supplement policies pay for custodial or intermediate care, the type of care elderly people are most likely to need. (One policy offered by Pyramid Life does cover stays in intermediate-care nursing homes.) Usually, though, you need to buy separate insurance for long-term nursing-home care. (see CONSUMER REPORTS, May 1988.)

Covering the medical gaps

Part B coverages separate the sheep from the goats in the field of supplemental policies. A surprising number of policies pay neither the $75 Medicare Part B deductible nor anything toward excess physicians'

WHAT AN INSURANCE PACKAGE COSTS

PLAN TO SPEND $2000 TO $3000

Medicare's hospital (Part A) benefits are financed solely out of Social Security payroll taxes. The Medicare portion of Social Security taxes flows into a separate trust fund earmarked for payments to hospitals.

Medicare's medical benefits (Part B) are financed from general tax revenues and by the beneficiaries themselves. Part B coverage is optional for those 65 and older. Those who elect coverage pay this year a basic monthly premium of $27.90 (this premium rises annually).

The Catastrophic Coverage Act requires beneficiaries to pay an additional amount on top of the basic premium. In 1989, that amount is $4 per month, bringing the total monthly premium to $31.90. In 1990, they will pay $4.90 extra; and in 1991, $7.40 more. The basic premiums are usually deducted from monthly Social Security checks.

The Act imposes an additional tax called a "supplemental premium" on all those eligible for Medicare benefits, whether or not they've chosen coverage under Part B. The premium is a surcharge on a beneficiary's Federal income taxes. In 1989, the surtax is $22.50 for each $150 of Federal taxes due, up to a maximum of $800 per individual.

This year, the average supplemental premium is expected to be $285, with only one-third of those 65 and older paying any at all. Only 5 percent (those with the highest incomes) will pay the maximum.

The table below shows how much a 65-year-old retiree should set aside to pay for health insurance in 1989. A person could easily spend between $2000 and $3000 for all health-insurance coverages, depending on the supplemental-premium tax and the price of both the Medicare-supplement and long-term care policies. Older retirees could pay more, since many insurance companies charge them higher premiums for these coverages. The average-cost package assumes a person would pay the average Medicare-supplemental premium this year and buy average-priced insurance policies. The high-cost package assumes a retiree will pay the maximum supplemental tax and can afford higher-priced policies. Everyone who enrolls in Medicare Part B pays the same basic premium regardless of income.

Items to budget	Average-cost package	High-cost package
Medicare Part B basic premium	$ 383	$ 383
Medicare supplemental premium	285	800
Supplemental insurance policy	635 [1]	987 [2]
Long term care insurance policy	642 [3]	918 [4]
TOTAL	**$1945**	**$3088**

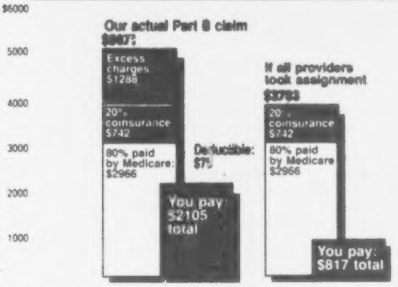
[1] *The annual premium for policy from Golden Rule, a Best Buy in our Ratings*
[2] *The annual premium for the top-rated Bankers Life and Casualty policy*
[3] *The annual premium for the high-rated Bankers Life and Casualty policy with home health care rider from our May 1988 report on long-term care insurance*
[4] *The annual premium for the high-rated John Hancock policy from our May 1988 report.*

charges, the most likely source of big out-of-pocket expenses. Many policies pay only the 20 percent coinsurance for the allowable charge.

Most plans sold by Blue Cross and Blue Shield organizations are these so-called 20 percent policies. A bare-bones 20 percent policy is also the best-selling plan in the insurance portfolio of AARP. While AARP does sell more generous plans, half of its policyholders opt for the 20 percent plan.

Through the years, AARP has advised its members to buy a minimum of insurance against doctors' bills and to seek out physicians who "participate" in Medicare—that is, physicians who have committed themselves to accept Medicare's allowable charge as payment in full all the time. We think that's unrealistic advice. Most physicians are not participating. Even if you find a family doctor who does accept assignment, an illness may require a team of medical and surgical specialists, at least some of whom are probably "nonparticipating." Finally, many people who reach Medicare age have long-established relationships with physicians and prefer not to bargain-hunt for new ones.

Anatomy of a claim



The graph above shows the breakdown of the actual claim we used to determine the Part B gap for the policies we rated. We also show the same claim assuming all medical providers accepted assignment.

We gave preference in our Ratings to policies that cover excess physicians' charges.

The percentage game

Policies that do cover excess charges cover them in different ways, creating great confusion for anyone trying to compare policies. The excess charge a policy pays is not always the same as the excess charge the doctor bills.

Insurers first define what they mean by excess charge for the purpose of calculating payment. Typically, they define an excess charge not as what the doctor may actually bill in excess of the allowable charge but as the excess charge up to a fixed percentage of the allowable charge. Standard Life and Accident, for example, says an excess charge is any charge up to 80 percent higher than the allowable charge. Other companies define an excess charge as any charge the company deems reasonable and customary. And still others use both limitations.

A policy may then further restrict its payment to a stated percentage of what it has defined as an excess charge. It may pay as much as 100 percent of what it says is an excess charge, or it might pay less. It may also make its payment for excess charges subject to a deductible.

It's easy to see how agents' sales pitches and promotional materials can create confusion by playing word games with the definition of excess charges. The claim most often made is that a policy pays 100 percent when, in fact, it pays considerably less than 100 percent of the actual bill.

Of the policies we examined, only the plan of First National Life was a true 100 percent plan, one that pays all excess physicians' charges.

Other features

Most companies tack a variety of features onto their basic coverages, hoping that one or two will distinguish their offerings from competitors'. These extras might include coverage for prescription drugs, care in a skilled-nursing facility not certified by Medicare or care in foreign countries. Some of these features are more valuable than others.

Foreign travel benefits are important if you plan to roam the world during retirement. But beware: Benefits vary greatly. Some policies offer no coverage unless Medicare pays; but, as we point out on page 378, Medicare rarely pays. Blue Cross and Blue Shield of Massachusetts pays the same benefits in a foreign country that it would pay in the U.S. plus the part Medicare would have paid. AARP offers limited coverage in foreign countries only for medical emergencies and accidents.

The Blue Cross plans, which tend to be deficient in the major coverages, often throw in a package of extras that at first blush seem more useful than they are. For the most part, we considered them frills.

For example, Blue Cross and Blue Shield of Massachusetts covers the services of a midwife, services a senior citizen is likely to use only in the case of a truly blessed event.

Blue Cross and Blue Shield of Maryland includes discount coupons, but we wouldn't recommend that anyone buy this policy to receive 20 cents off a package of *Dr. Scholl's* corn cushions or 85 cents off a box of *Depend* undergarments.

Blue Cross and Blue Shield of Colorado had the best package of features, offering valuable coverage for routine physicals and for vision and hearing examinations.

First National Life and Equitable Life and Casualty add accidental death benefits. If policyholders die in an accident, an unlikely event for older people, First National will refund the premiums; Equitable will pay a maximum of $5000 to a policyholder's beneficiary.

What's not covered

In general, policies pay only for the type of services Medicare covers. If Medicare doesn't pay for something, it's unlikely the policy will pay.

Some policies restrict coverage even more. Typically, the Blue Cross plans are the most restrictive: Blue Cross and Blue Shield of Tennessee, for example, lists 22 limitations and exclusions, including no coverage for removal of corns and callouses, or for "travel," whatever that means.

In contrast, Colonial Penn's policy has only one exclusion—no coverage for war injuries.

Many policies exclude coverage for mental and nervous disorders, although some are fussier than others. Pyramid Life excludes coverage for mental or emotional disorders, alcoholism, and drug addiction. AARP's plan is more liberal, excluding hospital coverage for mental, psychoneurotic, and personality disorders unless Medicare covers them.

Most policies also require a waiting period before they will cover you for those health conditions you have at the time the policy is written. Policies prescribe how long you must have had such a condition for the waiting period to apply. Some define a pre-existing condition as any ailment diagnosed within the last six months; others say the last three months.

The waiting period before coverage for pre-existing conditions begins is usually one to six months.

Surprisingly, a few companies offer coverage from day one for any health condition, and a few others allow policyholders to buy riders to shorten the usual waiting period. If you have a serious health condition, a policy with a shorter waiting period might be worth the small extra cost. For example, First National Life makes a one-time charge of $59.71 to shorten the waiting period from six months to one month. (The policy we rated did have this rider.)

Are you a good risk?

Many companies don't require physical examinations or doctors' statements before issuing the coverage. In fact, about half the companies represented in our survey, mostly Blue Cross organizations and AARP, take all comers, no questions asked. But many of the Blue plans offer policies with numerous restrictions and limitations.

Other companies are choosier, requiring applicants to meet certain standards. Rejection rates vary. Colonial Penn rejects less than 1 percent of all applicants while National Home Life turns down between 10 and 15 percent.

Golden Rule has the toughest standards, rejecting 20 to 30 percent of all applicants who are 65, and as many as 50 percent of those who are 70. "We look for the healthy risks," says Susan Puorro, a company marketing executive.

A few companies let their agents "underwrite" the policies. The agent will ask a few questions about your health; if your answers reveal serious problems, the agent won't even take the application.

A look at the premium

With many policies, the price you pay depends on your age. The older you are, the higher the premium, since you're more likely to need the coverage. Other policies, such as those from most Blue Cross and Blue Shield plans and AARP, charge "community rates"—everyone pays the same regardless of age.

No matter what the premium is when you buy the policy, it's likely to increase. Yearly rate increases are common.

Members of Congress who supported the Catastrophic Coverage Act last year had high hopes for a reduction in premiums for Medicare-supplement policies, since some of the costs had been shifted from the private-insurance system to Medicare. But that hasn't happened. Companies did eliminate the duplication in coverage between their policies and the improved Medicare coverages, but many then petitioned state regulators for rate increases, pleading that the ever-increasing costs of medical care outstripped any savings realized from the Catastrophic Coverage Act.

A few state regulators have begun to take a hard look at premiums to see if they're too high. They are scrutinizing loss ratios, a rough measure of a policy's premiums in relation to the benefits paid out, and finding them too low. In some states, regulators have denied rate increases if loss ratios were too low, but in others, companies have had carte blanche to charge what they wish.

Can it be canceled?

Eleven of the policies in our study cannot be canceled; in effect, they are guaranteed renewable for the life of the policyholder, a highly desirable provision. Others are conditionally renewable. That means the company can cancel the policy but must do so for all policies in the same class—for example, all policies in a particular state.

A few companies, though, can cancel any individual's policy without regard to similar policies. California Blue Cross can cancel any policy with 30 days' notice. Blue Cross and Blue Shield of Maryland can cancel whenever it wants unless a policyholder is about to go to the hospital.

Rating the policies

We asked 53 companies to send us information about their new policies, those written to supplement Medicare as amended last year by the Catastrophic Coverage Act. The U.S. General Accounting Office had identified these companies as the biggest players in the market. Twenty-five

AARP and its insurance carrier, Prudential, which has the second largest share of the Medicare-supplement market, raised premiums across the country an average of 40 percent. If it hadn't been for the Catastrophic Coverage Act, premiums would have increased even more, says an AARP official.

THE TOP-RATED PLANS

WHERE THEY ARE SOLD

This table lists the 10 top-rated plans and the states where they are sold. A company may be awaiting approval to sell this policy in states other than the ones listed here.

Company/Plan	Where sold
Bankers Life & Casualty Planned Insurance Coverage (GR-A002)	All states but New York
Pioneer Life New Ultimate Protector (IMP-9161 (Rev 11/88)-G)	Ala., Alaska, Ariz., Ark., Calif., Colo., Del., D.C., Fla., Ga., Hawaii, Idaho, Ill., Ind., Iowa, Kan., Ky., La., Miss., Mo., Mont., Neb., Nev., N.H., N.M., N.C., Ohio, Okla., Ore., Pa., S.C., S.D., Tenn., Tex., Utah, Vt., Va., Wash., Wis., Wyo.
Standard Life & Accident Medicare Supplement Policy (1232-1/89)	Ala., Ariz., Ark., Calif., Colo., Fla., Ga., Hawaii, Idaho, Ill., Ind., Iowa, Kan., Ky., La., Miss., Mo., Mont., Neb., Nev., N.M., N.C., N.D., Ohio, Okla., Ore., S.C., S.D., Tenn., Tex., Utah, Va., Wash., W. Va., Wyo.
Golden Rule Medigap Plus (GR1-H-12P)	Ala., Ark., Colo., Del., Fla., Idaho, Ill., Ind., Iowa, Ky., La., Maine, Mich., Miss., Mo., Nev., N.H., N.M., Ohio, Okla., S.D., Tenn., Tex., Utah, Va., Wyo.
Prudential, AARP AARP's Comprehensive Medicare Supplement (M7 FLA 1-89)	All states
Pyramid Life Medicare Supplement (G-15)	Ala., Ariz., Ark., Calif., Colo., Del., Ga., Idaho, Ill., Ind., Iowa, Kan., Ky., La., Md., Minn., Miss., Mo., Mont., Neb., Nev., N.M., N.C., N.D., Ohio, Okla., Ore., S.C., S.D., Tenn., Tex., Utah, Va., Wyo.
Colonial Penn Medicare Supplement Policy (4-82-594(09))	Ala., Ariz., Calif., Colo., Fla., Ga., Ill., Ind., Iowa, La., Mich., Mo., Neb., Nev., N.M., N.C., N.D., Ohio, Ore., Pa., S.D., Tenn., Tex., Va., Wis.
First National Life Medicare Supplement Policy (MS-189)	Ala., Alaska, Ariz., Ark., Colo., Del., Fla., Ga., Idaho, La., Md., Miss., Mont., Neb., Nev., N.M., Okla., Ore., S.C., Tenn., Tex., Utah, Wyo.
National Home Life Secure Care Preferred (NH-121-189FL(L))	Filing for approval in all states except Ky., Mass., Md., Mich., Minn., Wis.
Equitable Life & Casualty The New Ultimate (880) (89)	Alaska, Ariz., Ark., Colo., Hawaii, Idaho, Ill., Ind., Ky., La., Miss., Mo., Mont., Neb., Nev., N.M., N.D., Okla., Ore., S.C., S.D., Tenn., Tex., Utah, Wash., Wyo.

companies representing some 80 percent of the market sent us their most popular plan.

Many have other policies that offer more or less coverage than the one the company expects to generate the most sales. Since coverage for excess charges is so important, we also rated excess-coverage policies available from AARP, Mutual of Omaha, and Blue Cross and Blue Shield of Florida, even though they might not be heavily sold.

We determined a number of features that a good policy should have and assigned points to each, giving the most weight to how well the policies filled the remaining Part A and B gaps.

For Part A, our gap was hypothetical, based on the cost of hospital rooms in St. Petersburg, Fla., the cost of private-duty nurses, blood transfusions, skilled-nursing facilities, psychiatric hospitals, and supplemental hospice and home-health care.

For Part B, we used an actual claim submitted by a man who had fallen and needed complicated hip-replacement surgery. The medical bills totaled $5071. Medicare left $2105 uncovered.

The Part B out-of-pocket expense noted in the Ratings is our estimate of the cost remaining after each rated policy kicked in. (The claim also included a small prescription drug expense.) These out-of-pocket expenses ranged from zero for the policy of First National Life to $1467 for the Prudential plan most often sold by AARP.

We also looked at coverage for such things as care in foreign countries or for prescription drugs, and gave credit if the policy offered those extras.

We judged whether policies had too many exclusions and limitations, whether they were renewable for

RATINGS

Medigap policies

Listed in order of estimated overall quality. Except where separated by bold rules, differences between closely ranked plans were minor.

1 **Monthly premium.** This is the monthly premium for a 65-year-old woman living in St. Petersburg, Fla. For a company not doing business there, the premium is for the main area where it operates.

2 **Part A.** Refers to hospital coverage each policy provides. It can include payment of Medicare's $560 **deductible** and benefits for **private rooms** and **in-hospital private nurses**, the **skilled-nursing-home copayment** for the first eight days, and coverage for **skilled nursing beyond 150 days**.

3 **Part B.** Refers to medical coverage offered by each policy. It can include payment of Medicare's **$75 deductible**, coinsurance

Company	Policy	Telephone number	Monthly premium 1
Bankers Life and Casualty	Planned Ins. Coverage (GR-A002)	800-777-5775	$82.25
Pioneer Life	New Ultimate Protector (IMP-9161 (Rev. 11/88)-G)	800-752-4368	75.64
Standard Life and Accident	Medicare Supplement Policy (1232-1/89)	405-232-5281	73.24
Golden Rule, A Best Buy	Medigap Plus (GR1-H-12P)	317-297-4123	52.91
Prudential, American Assoc. of Retired Persons	AARP's Comprehensive Medicare Supplement (M7 FLA 1-89)	800-523-5800	110.50 6 11
Pyramid Life	Medicare Supplement (G-15)	913-722-1110	71.93
Colonial Penn	Medicare Supplement Policy (4-82-594(09))	800-523-4000, ext. 49	89.57
First National Life	Medicare Supplement Policy (MS-189)	800-289-3654 800-999-2224	85.00
National Home Life, A Best Buy	Secure Care Preferred (NH-121-189FL (L))	800-356-6271	47.95 4
Equitable Life and Casualty	The New Ultimate (880) (89)	800-633-3480	64.42
Blue Cross and Blue Shield of North Carolina	Plan 12 (Plan 12 K-999 1/89)	800-222-4816	59.04 6
Community Mutual Blue Cross Blue Shield (Cincinnati)	Mediplus (PD 003)	800-367-5892	51.37 6 10
United American	United American Medicare Supplement Plan (MC3 AB)	214-328-2841	84.00
Blue Cross and Blue Shield of Florida	Medicare Supplement P(VI) (7555-287)	904-354-3331 800-876-2227 East of Mississippi River	105.30
Blue Cross of Western Pennsylvania w/Penn. Blue Shield	65 Special and 65 Plus and Blue Shield 65 Special Agreement (65-Plus - DL (10/88))	412-255-7349	61.75 6
Blue Cross and Blue Shield of Colorado	Senior Preferred Individual Coverage	303-831-2043	88.80 9
Capital Blue Cross w/Penn. Blue Shield (Harrisburg)	65-Special Subscription Agreement	717-255-0820	45.75 6 10

life, and whether their pre-existing conditions clauses were particularly onerous. We also noted rejection rates, lapse rates, clarity of policy language, and major state enforcement actions against companies. (In this regard, the Ratings penalized National Home Life and Colonial Penn, because regulators had fined them for misleading advertising.)

Recommendations

Since the Catastrophic Coverage Act has greatly reduced a retiree's liability for Medicare's copayments, coverage for excess charges from physicians under Part B is a major reason to buy a Medicare-supplement policy. Even though your own physician may accept assignment, many specialists and surgeons don't, so you could still be stuck with a large bill not covered by Medicare.

Many Blue Cross organizations and AARP issue policies to anyone and charge everyone the same rate—desirable and, for some retirees, necessary features. But their best-selling policies didn't fare well on the coverage we considered most important. A policy that's readily available and cheap is no bargain if it doesn't also cover the most important risks.

Unfortunately, many buyers may have few choices other than the local Blue Cross plan, since the best plans are not universally available. Many of the high-rated companies (Bankers Life, Golden Rule, Pioneer Life, and Colonial Penn, for example) do not sell policies in New York, where Blue Cross plans dominate the market. For details on where the high-rated plans are sold, see page 381.

The plans in the top Ratings group all offer excellent coverage to fill the gaps left by Parts A and B of Medicare. They provide generous benefits for excess physicians' charges, leaving only between $75 and $775

◉ ◓ ○ ◒ ●

Better ← → **Worse**

of **20 percent of allowable charges**, and excess charges. We show **how excess charges are defined**, the **percentage paid**, and the **deductible** that applies, plus **out-of-pocket expenses for our sample claim**.

[4] Other coverages. Additional coverages and features a policy may offer.

[5] Foreign country. Whether a policy pays substantial benefits abroad.

[6] Renewability. A G indicates the policy is guaranteed renewable for policyholder's life. A C means it's conditionally renewable; a company can cancel all the policies in a particular class.

[7] Pre-existing illness. Indicates how many months policyholders must wait to be covered for illnesses they have at the time policy is issued.

[8] Policy restrictions. Refers to the number and severity of limitations and exclusions in each policy.

[2] Part A					[3] Part B										
Deductible	Private rooms	In-hospital private nurses	Skilled-nursing-home copayment	Skilled nursing beyond 150 days	$75 deductible	20% of allowable charges	How excess charges are defined	% paid	Deductible	Out-of-pocket expenses for our sample claim	Other coverages [4]	Foreign country [5]	Renewability [6]	Pre-existing illness, mos. [7]	Policy restrictions [8]
✓	—	—	✓	✓	✓	✓	All usual and customary charges above allowable charges	100	0	$ 104	—	✓	G	0	◉
✓	✓	✓	✓	✓	✓	✓	Up to 100% above allowable charges	100	0	104	—	—	G	1	◉
✓	—	—	✓	✓	✓	✓	Up to 80% above allowable charges	100	0	104	—	✓	G	0	◉
✓	—	✓	✓	✓	[1]	✓	All reasonable and customary charges above allowable charges	80	$50 overall	303	A,F	✓	C	6 [2]	◓
✓	—	✓	✓	✓	—	✓	All usual and prevailing charges above allowable charges	100	0	75	A	[12]	[13]	3	◓
✓	—	✓	✓	✓	✓	✓	Reasonable and customary charges up to 50% above allowable charges	100	250	775	S,T	[3]	G	3	◓
✓	✓	✓	✓	✓	✓	✓	Provider's regular charges above allowable charges	100	0	104	C	—	G	3	◉
✓	—	—	✓	—	✓	✓	All charges above allowable charges	100	0	0	A,D,AA	—	G	1	○
✓	—	—	✓	✓	—	✓	Up to 100% above allowable charges	50	0	704	A,U,BB	—	G	3	◉
✓	—	✓	✓	—	[5]	✓	Up to 100% above allowable charges	100	0	104	A,J	—	G	3	○
✓	—	✓	✓	—	—	✓	No coverage	—	—	1348	A,B,G,R	✓	G	6	◒
✓	—	✓	✓	—	✓	✓	No coverage	—	—	1273	A,H,M,O,P	[7]	G	[8]	◓
✓	✓	✓	✓	—	✓	✓	Reasonable and customary charges up to 50% above allowable charges	80	0	673	B	✓	G	2	◓
✓	—	—	✓	✓	✓	✓	Up to 20% above allowable charge	100	0	926	A,B,CC	[16]	C	3	●
✓	—	✓	✓	✓	—	✓	No coverage	—	—	1348	A,N	✓	C	0	●
✓	—	—	✓	—	✓	✓	No coverage	—	—	1273	A,B,K	✓	C	0	●
✓	✓	—	✓	✓	—	✓	No coverage	—	—	1467	—	✓	C	0	○

Ratings continued on next page

of expenses uncovered for the sample claim we used. These policies were liberal when it came to excluding and restricting benefits once a policy is issued.

Some of the policies in the second group also offer excellent coverage. The eighth-ranked policy, sold by First National Life, offered the best coverage for excess physicians' charges; it didn't place in the top group because it lacked other coverages we thought were important and listed a number of limitations and exclusions (as did several other policies in this group).

Policies lower in the Ratings offer less generous basic coverage and tend to be more restrictive once a policy is issued. Many don't pay the $75 Part B deductible. Note that the best-selling policy of the American Association of Retired Persons is only mediocre. It provides no coverage for excess charges, leaving $1467 of our sample claim uncovered, and does not pay the Part B deductible. The policy is, however, fairly liberal when it comes to exclusions and limitations.

Price, although not factored into the Ratings, is an important consideration in choosing a Medicare-supplement policy. Note that some of the excess plans cost less than many of the 20 percent policies. Someone paying $88.80 a month for a policy from Blue Cross and Blue Shield of Colorado, for example, would be better off with a policy sold by Golden Rule or Pioneer Life with their $52.91 and $75.64 monthly premiums.

The policies from Golden Rule and National Home Life merit a Best-Buy rating, offering policyholders excellent coverage at an attractive price. Golden Rule keeps its price down in several ways. First, it does not pay its agents high commissions to sell Medicare-supplement policies, a good practice in our view. Less desirable from the consumer's point of view is its practice of selling only to healthy people.

Golden Rule may simply refuse to sell you a policy if it suspects you are in poor health, and it won't promise to renew your policy even if it accepts you as a customer. Golden Rule's policy is only conditionally renewable. The company can cancel coverage as long as it does so for an entire class of policies in your state.

The policy from National Home Life is guaranteed renewable and offers good coverage at an excellent price. National Home Life sells its policies through the mail, bypassing agents and the costly commissions other companies must pay.

National Home Life may be familiar because of its association with Art Linkletter, the company spokesman who had appeared in a series of deceptive television commercials. The company appears to have cleaned up its act. Television commercials shown to our reporter were free from the misleading statements of previous offerings.

AARP's excess-coverage plan also offers excellent coverage; its benefits for excess physicians' charges are as generous as the top-rated Bankers

Company	Policy	Telephone number	Monthly premium
Mutual of Omaha	Mutualcare (M115)-Series 15774 with Percentage Plus Option Rider (8545M)	800-228-9999	$68.62 [9]
Prudential, American Assoc. of Retired Persons	AARP's Medicare Supplement Plus (M6 FLA 1-89)	800-523-5800	48.60 [6] [11]
Blue Cross of Greater Philadelphia d/b/a Independence Blue w/Penn. Blue Shield	65 Special-Blue Shield 65 Special (5093 1/89) and (66H-9/82)	215-448-3397	54.30 [6]
Blue Cross and Blue Shield of Massachusetts	MEDEX 3 (ME3)	800-258-2226	52.32 [6] [10]
Blue Cross and Blue Shield of Florida	Medicare Supplement P(V) (7553-287)	904-354-3331 800-876-2227 (East of Mississippi River)	40.70
Blue Cross of Northeastern Pennsylvania w/Penn. Blue Shield	65-Special Subscriber Agreement and Blue Shield 65-Special Agreement (PRAG-5 1/89) and (66H 9/82)	717-829-8500	47.20 [6]
Mutual of Omaha	Mutualcare (M115)-Series 15774	800-228-9999	43.96 [9]
Blue Cross and Blue Shield of Maryland	65 Choice Plus (3.923)	304-494-6817	65.66 [9] [10]
Empire Blue Cross Blue Shield (New York)	Enhanced Medicare Plus (DP-MED SUPP HO)	212-490-6868	61.75 [6] [10] [21]
Blue Cross Blue Shield of Tennessee	Blue Cross 65 Standard Contract (00-0-65 2/87)	615-755-5917	43.68 [6]
Blue Cross of California	Gold Plan (5332 1/87)	800-333-3883	87.00 [10]

[1] *Pays 20% of Part B deductible.*

[2] *Pays for loss due to pre-existing condition that was fully disclosed in the application.*

[3] *Provides for emergency care outside the U.S.*

[4] *First month's premium is $1.*

[5] *Payment subject to one-time $75 deductible.*

[6] *Same rate for all ages.*

[7] *Pays for emergency inpatient and outpatient care outside the U.S., up to a lifetime maximum of 365 days of hospital coverage.*

[8] *Policy does not refer to a waiting period for pre-existing conditions; company claims 6 mos.*

[9] *Premium increases when policyholder reaches higher age bracket.*

[10] *One-third of quarterly premium.*

[11] *Company expects this will be the premium July 1, 1989.*

[12] *Pays for 60 days of covered emergency care, 80% after $50 deductible with a $25,000 maximum.*

[13] *Group policy with individual certificates; other than extension of benefits rights, there are no rights to continue policy if group policy terminates.*

[14] *Pays deductible for outpatient hospital visits.*

[15] *Mass. physicians cannot bill for excess charges.*

[16] *Medical emergency/accident services up to the extent Medicare would have paid.*

[17] *Renewable at company's option unless policyholder has applied for hospital admission.*

[18] *Company can cancel entire class of policies with 5 mos. notice.*

[19] *Company can cancel with 30 days notice before subscription is due.*

[20] *Premium for Cincinnati.*

[21] *Premium for New York City region.*

Life and Casualty policy. But its $110.50 monthly premium makes it the priciest policy in our survey, almost $30 a month more than the Banker's policy. No wonder only 3 percent of AARP's policyholders have bought it. AARP members who want a policy with excess coverage would be better off considering any of a number of other excess-coverage plans in our survey.

Other considerations

Here are some other points to keep in mind when selecting a Medicare-supplement policy:

1. Buy only one policy. The Health Insurance Association of America, an industry trade group, estimates that almost one-fifth of all Medicare-supplement policyholders own more than one. There's no coordination of benefits with these policies; all will pay. But buying more than one is a waste of money. One good policy will cost less and do the job of several inadequate ones.

2. If you're eligible for Medicaid, don't buy a policy. Medicaid takes care of your bills.

3. If your income is low but not low enough to be eligible for Medicaid, consider joining an HMO rather than buying a Medigap policy. The amount you would pay for HMO services could be less than the price of a good supplemental policy.

4. If your former employer provides health insurance for retirees, take it. This coverage supplements Medicare and often pays excess charges. Furthermore, some employers subsidize the cost.

5. Do not buy policies that pay a flat amount for days in a hospital (hospital-indemnity policies), or dread disease and accident policies that pay benefits only if a particular ailment or accident should befall you.

6. If you're older or in poor health, consider a company that charges everyone the same rate and does not scrutinize every health problem prospective policyholders may have. Your premiums are likely to be lower. But be sure that the coverage is adequate. A lower premium isn't much help if the coverage is not what you want.

7. Conversely, if you've just turned 65 and are in good health, a company that charges lower premiums for younger people or one that carefully checks a person's health status may be the one you want. You'll benefit from lower premiums.

8. If your current Medicare supplement does not provide coverage for excess charges, ask your carrier if it offers another plan that does. Compare the cost of its plan with some of the high-rated ones in our survey. The company may waive the pre-existing conditions clause on the new policy if you upgrade your coverage.

9. Shop several agents and companies. Don't look only to your local Blue Cross plan just because it's familiar. Ask agents for the outline of coverage for each policy and compare them. If agents refuse to give you the outline or push only one plan, quickly show them the door. ■

[2] Part A						[3] Part B									
Deductible	Private rooms	In-hospital private nurses	Skilled-nursing-home copayment	Skilled nursing beyond 150 days	$75 deductible	20% of allowable charges	How excess charges are defined	% paid	Deductible	Out-of-pocket expenses for our sample claim	Other coverages [4]	Foreign country [5]	Renewability [6]	Pre-existing illness, wait. [7]	Policy restrictions [8]
✓	—	—	✓	—	—	✓	Reasonable and customary charges up to 50% above allowable charges	100	0	$ 600	C,F	✓	C	6	◓
✓	—	✓	✓	✓	—	✓	No coverage	—	—	1467	—	[12]	[13]	3	◓
✓	✓	—	✓	✓	[14]	✓	No coverage	—	—	1467	—	✓	C	6	◒
✓	—	✓	✓	✓	✓	✓	No coverage [15]	—	—	[15]	A,G,I,L,V,W,X	✓	C	0	○
✓	—	—	✓	✓	—	✓	No coverage	—	—	1461	B	[16]	C	3	●
✓	—	—	✓	✓	—	✓	No coverage	—	—	1467	—	✓	C	6	◒
✓	—	—	✓	—	—	✓	No coverage	—	—	1467	C,F	✓	C	6	◓
✓	—	—	✓	—	✓	✓	No coverage	—	—	1273	A,E	✓	[17]	2	◓
✓	—	—	✓	—	✓	✓	No coverage	—	—	1273	A,Q,Y	✓	[18]	6	●
✓	—	—	✓	✓	—	✓	No coverage	—	—	1467	B,Z	✓	C	6	●
✓	—	—	✓	—	—	✓	No coverage	—	—	1348	A	✓	[19]	6	●

Key to Other Coverages

A–Substantial out-of-hospital prescription-drug benefit.
B–Automatic receipt of claims.
C–Home-health care.
D–Waiver-of-premium benefit.
E–Network of providers for dental, vision, and hearing services offering discounts of 30 to 60 percent.
F–Skilled-nursing care in a facility not approved by Medicare.
G–Chiropractic services beyond what Medicare recognizes, if medically necessary.
H–Therapists beyond those that Medicare recognizes.
I–Enteral formulas, freestanding diagnostic imaging systems.
J–Accidental-death benefit.
K–Package of features includes coverage for prescription drugs, durable medical equipment, oxygen, private-duty nurses where no intensive-care unit exists, routine physicals, vision and hearing examinations.
L–Pays $8 per day in non-Medicare participating skilled-nursing facility which participates with Massachusetts Blue Cross.
M–Certain private nursing services at home.
N–Emergency-ambulance service.
O–Catastrophic major-medical benefit, including prescription drugs, physical therapy, and outpatient psychiatric services.
P–Outpatient psychiatric services.
Q–Hospice benefits.
R–"Costwise participating doctor program."
S–Pays in skilled- and intermediate-care nursing facilities whether or not approved by Medicare.
T–One mammogram screening.
U–Pays benefits for in-home recovery services following stay in a hospital or skilled-nursing facility.
V–Certain therapist services.
W–Licensed independent clinical social workers.
X–Coverage for Blue Shield participating nurse midwives.
Y–Private-duty and visiting-nursing services.
Z–Rental of wheelchair and durable medical equipment, orthopedic braces, independent laboratory exams, oxygen, anesthetics, physical therapy, and ambulance service.
AA–Accidental-death benefit (not allowed in Fla.).
BB–Membership in Eye Care Plan of America.
CC–Vision-care benefits.

BEYOND MEDICARE

THE INSURANCE HARD SELL

In April 1988 Allen Quinn Bounds of Pearl, Miss., received a card in the mail from Senior Citizens Health Services advising him of "new changes in Medicare." The card arrived in an official-looking black and white envelope and noted that the total health-care bill for seniors in 1984 was $120-billion, more than half of which was not paid by Medicare. The card warned that "effective on January 1, there were even more expenses for the Senior Citizen to pay" and that it was "very important" for Bounds to know about them.

Bounds was instructed to complete the card with his name, address, telephone number, age, and Social Security number and send it to a post office box in Dallas. In return, he would receive "information" on how to protect himself against "costly Hospital, Doctor, and Nursing expenses."

Nowhere on the card was there any hint that the "information" would come from an insurance agent, nor that the purpose of the card was really the sale of insurance.

If Bounds returned the card, his name could be sold as a "lead" to an insurance agent prospecting for buyers of Medicare-supplement policies.

A year earlier, an identically worded card sent to Californians by The Mail Box, a Dallas firm, was declared illegal by California insurance regulators, who decreed that the cards could no longer be sent into the state because they were misleading and deceptive. Insurance regulators in Mississippi apparently are not bothered by such deceptions.

Neither are regulators in most other states. Similar cards are flooding the mailboxes of senior citizens across the country.

The growth of Medicare-supplement policies has spawned an industry of deceptive mailings whose purpose is to deliver your name, address, and phone number to insurance agents. This "lead-card" industry, based in Texas, has largely been ignored by state insurance regulators and U.S. postal authorities.

Tricks of the trade

The lead-card companies buy names from firms that compile mailing lists, then send out deceptive mailings to the names on the lists. If you fill in and return the card enclosed in the mailing, the card will be sold to insurance agents for as much as $19 apiece. The lead cards provide an entree to the living rooms of the elderly, where agents may persuade their "prospects" to switch policies, take more coverage than they need, or buy insurance policies that will not live up to the agents' promises.

A CU reporter posed as an agent and asked seven lead-card companies to send her samples of cards she could buy, along with price lists. What she received should have been enough to raise the hackles of the meekest state regulator.

The companies go to any lengths to persuade consumers to return the cards, distorting the Medicare program and raising fears of huge unpaid medical bills.

Misrepresentation and deception begin with the names used on the cards to make retirees think that the sender is a government official. While most cards disclose in tiny type at the bottom that the companies are not affiliated with Medicare or any government agency, one can hardly miss the import of such names as: Retired Persons Information Center; National Health Information Center; National Processing Office; Regional Processing Center; National Health Referral Services; Consumer Referral Service Center, Medicare Division; Information Distribution Office; or Senior Citizens Health Services. To further the impression of a government connection, some companies direct recipients to return the cards to post-office boxes in Washington, D.C.

A few lead-card companies masquerade under names likely to be confused with well-known consumer and retiree organizations like the American Association of Retired Persons.

The imitators claim to provide services for retirees. But the services are largely limited to brochures. Some brochures advertise senior-citizen discounts, many of which seniors could obtain on their own. Others provide information on subjects ranging from flu prevention to finding the right lawyer. The National Federation of Retired Persons, for example, offers 16 brochures that are merely reprints of pamphlets published by the U.S. Department of Health and Human Services; they're available to anyone from the Federal government's Consumer Information Center in Pueblo, Colo.

The art of crafting a successful lead card lies in disguising its connection to insurance. The card must kindle enough interest in Medicare to encourage a response, but without arousing suspicion that an insurance agent will call.

A sales representative for National Referral Systems advised our reporter to avoid sending "qualified" lead cards—ones that mention the word "insurance" or identify a specific insurance company or policy. With these cards, she warned, "it's easy to get 'porched.' They won't let you in the door." National Referral's sales literature advertises that its promotions are successful because "a company name or agent name is not noted on the mail piece."

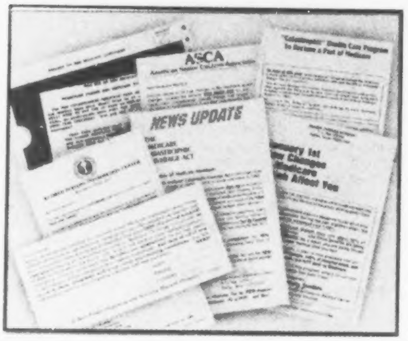
Some lead cards do refer to a "plan" or "program," but avoid tying it to "insurance." A favorite trick is to link the plan to the words "100 percent" to imply that the sender will rush details of something that pays every penny of a person's medical bills. But lead-card companies send nothing to consumers, and the chances are slim indeed that every agent who comes calling will actually sell the rare plan that pays every bit of every claim.

Regulators take a walk

Failing to mention the word "insurance" next to the word "plan" is a violation of the advertising regulations for accident and health policies adopted by 48 state insurance departments. The regulations also direct that "advertisements shall be truthful and not misleading in fact

DECEPTIVE SALES TACTICS

A LEAD CARD SAMPLER



Companies mailing lead cards latch onto any change in Medicare to pique consumer interest. "Right now anything with catastrophic on it will pull," said a sales representative at National Referral Systems. "In effect the Catastrophic Act has been turned around to help us. We can market that very easily."

And market it they do, as the cards sent to our reporter show.

The message on the card from the "Tax Savings Information Services," a trade name used by The Mail Box, announced: "Important: New Catastrophic health bill effect . . . Congress and the President are now proposing new stopgaps in your Medicare coverage . . . Warning . . . It is very important that you find out about the changes under this new bill, because previous information will no longer be current."

What were the "stopgaps" Congress proposed? None. But the words conveyed a sense of urgency designed to make someone return the card.

A lead card from the "Retired Persons Information Center Washington, D.C." made this dire pronouncement: "During the past seventeen years, your share [of Medicare's costs] has increased over 800 percent and according to the government's latest report, 'Congress has approved an additional One Billion Dollar Cut in Medicare payments.' "

The fears raised by the card are unfounded. Over the years, beneficiaries' share of Medicare's costs has actually gone down. For Part B alone, their share has decreased from about 65 percent in 1975 to 47 percent in 1985. True, Medicare has cut payments to doctors and hospitals. But it has *not* touched those made to beneficiaries, as the lead card implies.

Nevertheless, the Retired Persons Information Center, a trade name used by U.S.A. Lead Systems, had "found a new program that can help solve this National problem." What was it? An insurance policy, of course, that paid "100 percent of the HOSPITAL and pays on DOCTOR'S charges both IN and OUT of the hospital."

Since Medicare pays 100 percent of the hospital charges, except for the deductible, and all Medicare-supplement policies pay some physicians' fees, we asked what program the Center had in mind. The manager of lead sales admitted that the Center had no program, and that the card was loosely worded so any insurance agent could use it.

National Referral Systems sent seven cards for our reporter to choose from. One, a "special bulletin" from National Referral's "Dispersement Office," says, "For the first time in history, Congress has adopted a new system of regulating Medicare and Catastrophic protection payments under the new Catastrophic Protection Act [sic]. Because of these regulations, many hospitals are transferring patients to lower-cost nursing homes or similar EXTENDED CARE FACILITIES."

The Catastrophic Act did not institute a new regulatory scheme as the card suggests. The DRG-payment system the card refers to was adopted four years earlier.

The Dispersement Office warned seniors "it is very important that you know about these regulations," and urged them to complete the card "immediately." It promised to "rush you complete information concerning the new changes in Medicare."

Despite its promise, the Dispersement Office rushes nothing to senior citizens. Information comes directly from the insurance agent who has bought the leads.

Another card from National Referral's "Senior Citizens Division" warned that "the Federal Medicare System pays only about 50 percent of your medical expenses . . . and those benefits are being significantly REDUCED."

Benefits reduced? Hardly. The Catastrophic Act significantly increased benefits, and for many seniors, Medicare pays much more than half their medical expenses.

American Response Marketing also sent several sample cards. One from the "American Senior Citizens Association Medicare Information Dept., Washington, D.C." asked: "Are you aware of the new changes in our Medicare system? These changes increase the amount YOU MUST PAY for your personal health care."

The card advised that the Association would furnish "information concerning the new changes and a supplemental plan which will help pay the expenses not paid by Medicare."

Does the American Senior Citizens Association actually furnish a plan? "No, we don't have a plan that I'm aware of," said a sales representative in Dallas. She did say that agents could give prospective policyholders a packet of material about the association. The sample packet sent to our reporter contained brochures advertising discounts on everything from bird feeders to Bibles, but not a single word about insurance.

A card from the National Federation of Retired Persons advised that at its "recent annual meeting" it reviewed several Medicare-supplement plans and found some so exceptional that "if you act now, these programs will even cover pre-existing conditions"—obviously appealing to those with chronic health conditions.

We did find some plans with no waiting periods before coverage begins for existing health problems, but doubt these are the same policies National Federation of Retired Persons had in mind. None of the policies it submitted to Washington state regulators in response to a subpoena to substantiate lead-card claims were the ones we found without pre-existing conditions clauses.

In fact, the sketchy brochures National Federation did submit showed that four policies actually *limited* coverage for pre-existing conditions. We weren't sure about the fifth, since the brochure furnished too little information.

or in implication," and must not "create undue fear or anxiety in the minds of those to whom they are directed." Furthermore, most states have "little FTC" laws that allow their attorneys general to file lawsuits against companies engaging in misleading and deceptive practices.

But with the exception of insurance regulators in Washington, California, Oregon, Wisconsin, and Florida, and the attorney general of Illinois, state enforcement agencies have hardly questioned the activities of lead-card companies.

Last year, the attorney general of Illinois obtained a consent judgment against Senior Citizens Marketing Group under which the company agreed not to engage in certain deceptive practices. It obtained from National Referral Systems an assurance of voluntary compliance for similar practices.

But cards that trouble a regulator in Washington, California, or Illinois may cause no concern in New York or Mississippi. National Referral's sales representative told our reporter, based in New York, that the company could send anything it wanted to New York because regulators there "look the other way. They don't pay attention to what we mail."

Cards that fall afoul of regulators in some states soon pop up in others where regulators don't seem to mind. "We were hoping that by filing one or two cases, we'd send a message, but obviously we haven't," says Delores Martin, an assistant attorney general in Illinois.

Sometimes cards outlawed in one state are sent unchanged to consumers in others, like the one The Mail Box sent to Allen Quinn Bounds in Mississippi. But other times a company changes the name and slightly alters the message before sending a card to another state. Senior Citizens Marketing Group, for instance, sent our reporter in New York a card worded almost—but not exactly—the same as a card outlawed by the Illinois attorney general in early 1988.

Because it's easy for a company to change the name and the message on its cards, and because different companies use similar trade names, even tough regulators have trouble insuring compliance with their orders.

Our reporter found that a lead card from National Referral Systems using the trade name National Health Referral Services had been sent to consumers in the state of Washington several months after the insurance commissioner ordered Consumer Referral Service Center and its affiliates (including National Referral Systems) to stop sending misleading and deceptive cards.

The card we found purported to be taking a survey of senior citizens' attitudes toward the catastrophic health-care legislation then making its way through Congress. Was National Referral really taking a survey? "No," said a sales representative, "but it was a real neat card."

Regulators in Washington state also ordered all the affiliates of American Senior Citizens Association (including American Response Marketing) to stop sending deceptive cards into the state. A card sent to our reporter by American Response Marketing was identical to one that was mailed to Washington residents after regulators had issued their cease and desist order. This time the card used the name National Health Information Center.

Some of the lead-card companies didn't want to talk to us about their business. Morris Kuhn, of U.S.A. Lead Systems, said his company was not mailing lead cards for Medicare-supplement policies. "Get someone here and try to get them to get a card. We don't have anything to mail," Kuhn said. Two weeks earlier, our reporter had phoned U.S.A. Lead Systems and received a sample card and price list for Medicare-supplement policies.

Al Wilburn, president of National Referral Systems, said his company was not mailing any lead cards unless they had been approved by specific insurance companies and by state regulators. But our reporter obtained seven sample cards from National Referral, and none referred to a specific insurance company or product. National Referral's sales representative was only too willing to tell our reporter how to use the cards successfully.

Fiction: This policy pays 100 percent of your bill.
Fact: It pays only 50 percent of excess charges up to 100 percent above Medicare's allowable charge.

Fiction: All Medicare policies are alike.
Fact: We found big differences among policies.

A sorry tale in Texas

While lead-card companies appear to be unrelated to one another, their modus operandi is the same, probably because over the years, principals of one firm or another have left to start their own version of the business.

Except for U.S.A. Lead Systems, none of the lead-card companies seems to be backed by well-known insurance companies. U.S.A. Lead Systems uses a first-class mailing permit issued to AMEX Life Assurance Co., a subsidiary of American Express and a big seller of long-term-care insurance. (Agents use similar lead cards to find customers for long-term-care policies.)

Many of the companies began operations in the late 1970s or early 1980s, but until recently, Texas insurance regulators and the state attorney general have done little to stop their home-grown scam.

Eight years ago, the Texas Board of Insurance concluded it could do nothing to stop the lead-card companies since they did not actually sell insurance and thus were not under the jurisdiction of the board or any

Fiction: Medicare has cut the approved amount by 467 percent. **Fact:** Medicare has not cut the approved amount for beneficiaries.

of its statutes and regulations. (Regulators in other states have taken action against companies precisely because they *were* acting as unlicensed agents soliciting insurance in violation of state laws.)

"While lead-card solicitations may be annoying, they are not where you have substantial misrepresentation," says Tony Schrader, a division director for the Texas Board of Insurance. "The misrepresentation is with the agent. They [the cards] may add a beginning foundation that is bad, but the real problems are in the actual sale."

Delivering the pitch

The history of Medigap policies is littered with cases of agent abuse—overselling, misrepresentation, deception, and outright fraud. Despite numerous Congressional hearings and laws prohibiting misrepresentation and the sale of duplicate coverage, these abuses are still alive and faring all too well.

Our reporter, posing as a family relative, listened to seven sales pitches given to old people in California and Texas and found them sprinkled with enough exaggerations, half-truths, misstatements, and violations of insurance laws to confound even the most knowledgeable buyer.

In California, the first agent she listened to is a defendant in a case brought by the district attorney in Santa Cruz. He's charged with engaging in unfair business practices, specifically selling excessive insurance coverage. But the charges apparently had made little impression. He tried hard to persuade his 84-year-old prospect to sign a check totaling $4673 to cover premiums for a Medicare-supplement policy, plus long-term-care and home-health-care policies.

His pitch deftly moved from lower-priced policies to higher-priced ones, which, of course, would bring the highest commission. He trashed AARP's policy, and said United American's policy with its $924 annual price tag was "okay if that's all John [the prospective buyer] can afford." The agent had his heart set on selling the policy of Garden State Life Insurance Co. with an annual premium of $1291.

When the prospect said he could not afford a policy now, the agent stepped up the pressure: "Can you afford not to have it? I'm trying to convince you to get something. You're sitting here with nothing, and this premium is not out of line for a little over $100 a month." As it turned out, the man did own a Medicare-supplement policy; the agent didn't bother to ask about it.

When no amount of cajoling worked, he left, leaving no brochures, no literature, and no outline of coverage, as required by the California Insurance Department.

Another agent also began his pitch by knocking the competition. "Blue Cross and Blue Shield plans are not recommended," he advised. (That was one of the few true statements he made. The policy submitted by Blue Cross of California was dead last in our Ratings.)

He then told his prospective buyer, an 80-year-old woman, that she should take a private room when she went to the hospital so she wouldn't "be susceptible to all the stuff that's going around." It so happened that the Pioneer Life policy he was promoting paid for private rooms, a luxury hardly central to the value of a Medicare-supplement policy.

This policy, he said, "paid six times more," a figure pulled out of thin air. Later he said it paid "double what Medicare approves. This is the most liberal contract in the country." (Pioneer's policy, while a good one, is not the most liberal one we found.)

When asked for literature to back up his claims, he replied: "I could give you a thousand brochures, and they all say the same thing." When he finally produced one sketchy piece of printed information, it was not the outline of coverage required by California regulators.

The third agent wanted to know how much money his prospects had in the bank, a vital clue to how expensive a policy he could sell. He sold a variety of plans, explaining them in a very confusing way. Finally, he recommended that the 65-year-old woman and her husband buy a policy from Standard Life and Accident Co.

This policy, he said, "paid 100 percent of what was uncovered in the doctor area"—a true statement only if the doctor's excess charges did not exceed 50 percent of Medicare's allowable charges. That's all the outline of coverage said the policy would pay. (This policy was not the same one we rated.)

The top of the outline disclosed that the policy "does not usually cover custodial care," and another page said unequivocally that the policy did not pay for such coverage. But the agent insisted that it did, offering as proof a memo from the home office saying the coverage was provided by a rider.

When our reporter looked closely at the memo, she discovered the riders were for other policies, not the one this agent was selling.

Another California agent was peddling fear along with insurance. He said Medicare approved less than 50 percent of the bill, and since 1981, it had cut the approved amount by 467 percent.

To allay the fear that this and other falsehoods aroused in his 75-year-old prospect, the agent produced Garden State's policy, which

Fiction: Medicare benefits are being significantly reduced. **Fact:** The Catastrophic Coverage Act has significantly expanded benefits.

he said "pays 100 percent of the bill—the only plan that pays 100 percent of the charges without a limit."

That statement was also false. The outline of coverage said the policy paid 100 percent of charges that were "usual" and "customary."

One of the agents in Texas took a different tack, claiming "a 100 percent policy is a thing of the past" because "they're too expensive." He showed a policy from United American. "It's a full 100 percent policy; it pays for everything, but I'm not going to tell you to buy it," he said. The agent then showed another United American policy, insisting it would pay all but $200 of a claim. A few minutes later, he added that if a doctor charged a lot, the amount not covered might be more. His prospect was confused.

Another Texas agent also favored United American. "There's nothing better on the market," he proclaimed. We found several policies better than United American's.

Our reporter did find one bright spot in her otherwise dismal shopping trip. One Texas agent called at the last minute to cancel his appointment. He begged off saying that he wanted to sell only the policy from Golden Rule, and that new brochures and sales material had not yet arrived. Golden Rule's plan was the best on the market, he said, adding it wouldn't be fair to present old brochures, since the benefits had changed.

He was right on both counts.

The failure of regulation

In the early days of Medicare, the 50 state insurance commissioners put few restraints on the sellers of Medigap policies. In the resulting free-for-all, *caveat emptor* was the watchword. There were no standards for policies and misleading sales pitches were more rule than exception.

But in 1980, after well-publicized hearings, Congress passed the so-called Baucus amendments (named for Sen. Max Baucus, a Democrat from Montana). The amendments ordered regulators to set minimum benefits for policies, or the Federal government would do it for them. Fearing Federal regulation, states quickly adopted standards that required policies to cover the 20 percent Medicare copayment and meet a target loss ratio of 60 percent. (The loss ratio is an indicator of whether policyholders are receiving good value for their money; in general, the higher the better.)

The Baucus amendments also attempted to crack down on agent abuse by making it a Federal crime to impersonate a Medicare official and to sell duplicate coverage. Only one case has been brought for the first offense, and that never came to trial. Despite the mountains of anecdotal evidence that selling duplicate coverage continues, the Health Care Financing Administration has received few complaints and has closed most of those without taking action.

To run afoul of the law, an agent must *knowingly* sell a policy that duplicates another. One way not to know is not to ask. So many agents don't bother asking if a prospect already has a policy. If a sales solicitation gets to the application stage, many companies require their agents to note whether the policy being sold will replace another. Such requirements on the part of insurance companies have been a weak control at best.

Furthermore, the law says a policy duplicates another only if it won't pay when the other does. Since there's no coordination of benefits with these policies, and each will pay, there's no duplication in the eyes of the law.

"A lot of state officials think things got cleaned up with Baucus," says an investigator with the U.S. General Accounting Office. Indeed, regulators in Maine told us that the Baucus amendments "cleaned up the systemic problems in this market," and only an "occasional problem" arises. New Jersey regulators said they had found no evidence of sales abuses.

If regulators think the Baucus amendments cleaned up the Medicare-supplement industry, they're living on another planet. Sales abuses still abound, misrepresentation continues unabated, and there's evidence that some policies haven't achieved the target minimum loss ratios the standards require.

Surveying the states

To see how well states were regulating Medicare-supplement policies, we sent a questionnaire to all 50 insurance commissioners. Thirty-seven responded. With few exceptions, we found, most states are regulating with a velvet glove.

In 1985, the General Accounting Office found that many states had no system for tracking complaints about Medicare-supplement policies. In 1989, our survey showed they still don't have them. Twenty-three regulators could not tell us how many complaints had been made to their departments in the last five years. These complaints, they said, were lumped together with others, making it impossible to know whether Medigap policies were even a problem. A few other regulators said they had just started keeping records. Some didn't even bother to answer the question.

Nor could some of the states tell us how many enforcement actions they've taken against agents in connection with the sale of these policies. Only nine listed any fines, license revocations, or suspensions for agents who had sold Medicare-supplement policies, and no doubt some of these were for failing to forward premiums to insurance companies rather than for deceiving the elderly. A few regulators did say they had taken enforcement actions, but didn't know how many, since their record-keeping system is still in the Dark Ages.

Some acknowledged they did not regularly review advertising and sales materials, although if a violation stared them in the face, they would pursue it. Only eight states reported any penalties against companies for misleading advertising.

Michigan regulators require prior approval of all advertising and sales material, but said the number and names of companies penalized for misleading and deceptive material were "not available." We always thought enforcement actions of public agencies were public—that is, if there are any.

Fifteen regulators did not routinely monitor policy loss ratios for both individual and group policies. Without such a program how can they know whether policies sold in their states meet the target loss ratios required by the Baucus amendments? To their credit, some states were on top of this problem. Regulators in Arizona, Colorado, Florida, Kansas, Missouri, Pennsylvania, South Dakota, Washington, and Wisconsin either provided us with lists of policies that didn't meet the standards, or indicated they had taken action to bring policies into compliance.

Even though many state regulators appear to have a weak or nonexistent enforcement program, they believe their laws are adequate to deal with Medicare-supplement policies. Louisiana-regulators, for instance, told us they had no difficulties prosecuting agents. But how would they know? Louisiana regulators said the number of enforcement actions against agents was "undeterminable."

What's to be done?

The problems surrounding the sale of Medicare-supplement policies are systemic ones, calling for systemic solutions.

More doctors should accept Medicare's allowable charge as payment in full. States can mandate that they do, or the Federal government can beef up financial incentives to make it more attractive for doctors to become "participating" physicians.

If all doctors were participating, then policies providing excess coverage would be unnecessary; a simple and cheap plan of the type offered by Blue Cross and Blue Shield and the AARP would be enough.

Until the Federal government solves this larger problem, state regulators could take some immediate steps to ensure that buyers of Medigap policies are not victimized by unscrupulous sales people.

☐ The high commission paid to agents is the engine that drives the abuse. If first-year commissions were slashed, and companies were required to pay level commissions, for, say, the first four years, the incentive to misrepresent and replace policies would vanish.

☐ Policies should contain coordination-of-benefits clauses, or at the very least, the Baucus amendments should be rewritten to define duplicate coverage to mean coverage of the same expenses by two or more policies.

☐ Most regulators require agents to give policyholders an outline of coverage that summarizes the provisions of a particular policy. These outlines can be used effectively to compare policies if they are provided when buyers are actually shopping. The trouble is, regulators require agents to leave the outlines at the wrong time—when an application is taken and buyers have made up their minds and handed over a check to the agent. That's too late. Outlines must be given at the time of solicitation, whether or not an application is taken.

☐ Standardized policies would also help eliminate the confusion buyers now face. Many companies have several offerings with only slight differences among them. A few states require companies to offer only three types of policies, each with different levels of benefits.

Language in the policy and in accompanying sales brochures must be simplified to eliminate the impression that a policy pays a greater amount of the excess charges than it actually does.

☐ A few states, such as Washington, California, and New Jersey, operate insurance counseling programs for the elderly. These have saved money for senior citizens and helped them buy appropriate coverage. Other states should consider establishing such a service.

☐ The National Association of Insurance Commissioners (NAIC) should establish a standing committee to review advertising and approve its use in all states. But in the meantime, regulators should pay more attention to the enforcement actions taken by other states and reported to the NAIC's clearing house. The insurance commissioner in Mississippi should have known that lead cards sent into his state were illegal in California. This should have prompted him to take action, too, sparing Mississippi residents the blandishments of high-pressure agents. States have had 20 years to regulate this industry effectively. Most have missed their chance. They shouldn't be allowed many more. ■

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HOW UNCLE SAM FAILS

THE CASE OF THE TARDY REPORT

It's tempting to say the Federal government should regulate Medigap policies, most of the states having done such a poor job. But if the seven years it took the Health Care Financing Administration (HCFA) to issue a report on how well the states were regulating these policies is a guide, then the Federal government can't be expected to do much better.

The report, a victim of political maneuvering, industry lobbying, and bureaucratic bungling, would have helped Congress determine whether state regulations were working to clean up the industry.

The 1980 law also directed HCFA to prepare a report on the effectiveness of state regulation by January 1982. That report was to cover not only Medigap policies but also related dread-disease insurance and hospital-indemnity policies. Congress was specifically interested in whether the policies were meeting their target loss ratios, a rough measure of a policy's value to the consumer, and the heart of the mandated standards.

From the start, the report ran into trouble. Fifteen months after the order from Congress, the agency finally contracted with an outside firm to do the research. But the collection of data ran into snag after snag, partly because some companies selling dread-disease policies (which provide coverage only for specific illnesses) refused to cooperate.

The first draft was completed by the end of 1984, but there were at least 12 more drafts, each of them subject to political pressure and numerous revisions. At one point, a reviewer required the deletion of material critical of Medicare-supplement policies because it had been supplied by a committee chaired by Rep. Claude Pepper, Capitol Hill's champion of the elderly. The reviewer wrote on the report: "Claude Pepper's Committee. This is insane. We are Republicans. Remember, we don't agree with Claude Pepper."

The HCFA officials who had opposed the report eventually left the agency, and some of the survey data made it into the hands of certain members of Congress, but that didn't mean the report was back on track. Congress was now considering catastrophic health-care legislation, and bureaucrats at the Office of Management and Budget, which reviews the agency reports, reasoned that they couldn't issue a report critical of the way private insurers handled supplemental policies if the Reagan Administration also wanted private insurers to provide coverage for catastrophic illness.

No one needed to worry. The report that finally surfaced in 1987 was watered down and brief. By that time, Congress had lost interest.

Pocket guide to money

How to shop for CDs

or the first time in four years, double-digit returns are blossoming again on bank certificates of deposit. CDs, as they are called, are savings accounts that tie up your deposits, usually in amounts of $100 or more, for anywhere from seven days to 10 years. Diligent shoppers during the first weeks of spring could find six-month CDs yielding as high as 10.47 percent.

And in an ad blitz reminiscent of the era of free toasters, many banks are offering premiums on long-term CDs ranging from telephones to Cadillacs. As usual, such promotions distract shoppers from the hard data they should focus on. A certificate of deposit is an investment measurable in the dollars and cents it will earn. Gift premiums thrown in are part of those earnings, as customers discover at tax filing time, when the bank sends them and the IRS a Form 1099 reporting the value of the premium.

To shop intelligently, you need to know some basics: what CDs are, where they are sold, and in what variations.

Anatomy of a CD

A CD is a time deposit. For banks to attract money they can count on keeping for a stated period, they must offer higher interest rates than on demand deposits—checking, savings, and money market accounts—which can be freely withdrawn.

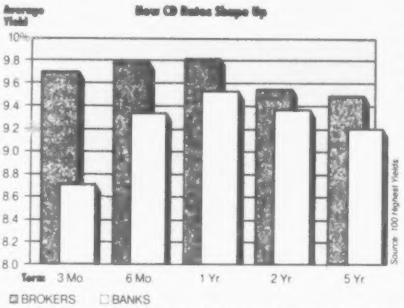
Most CDs mature in periods ranging from one month to ten years, with six months, one year, 2½ years and five years the commonest. If you withdraw your money from a bank CD before the CD matures, you pay a penalty—usually an amount equal to three months' interest on CDs of less than one year and six months' interest on longer-term certificates.

Interest rates on CDs ordinarily go higher as your time commitment lengthens. That stands to reason, because the longer you are locked into a CD, the greater the risk that interest rates will rise, making your own rate less desirable. Earlier this spring, however, the "yield curve" took a strange turn, with one-year CDs paying higher returns than longer ones (see chart).

Where to buy them

As bonafide bank deposits, CDs enjoy the protection of Federal deposit insurance up to $100,000. They are issued by commercial banks, savings and loans, savings banks, and credit unions.

You can also buy insured bank CDs through stockbrokers. On average, as the table shows, brokerage-house CDs pay the highest rates. With a brokerage CD, you may also be able to get your money back without paying a penalty. You cannot cash in CDs bought from brokers, but you can usually have the broker sell them for you. There is no penalty, but the market price may be lower than your initial investment if interest rates meanwhile have risen.



Source: 100 Highest Yields

In April, new one-year CDs were paying the highest effective annual yields. CDs sold through brokers (charted in color) were maintaining a wide edge over those sold directly by major banks.

CDs from some brokers have one serious disadvantage: the interest does not compound. Instead, you can arrange for the payouts to be reinvested in a money-market fund (see Pocket Guide, May 1989), where they will continue to accumulate interest, but at a fluctuating and unpredictable rate.

Shopping the rates

Although brokerage CDs pay higher-than-average rates, you can generally find some banks around the country offering up to a quarter of a percentage point more.

Barron's, a weekly business and financial newspaper sold on newsstands, publishes in each issue a list of the banks paying the highest interest on CDs. Or, for $29, you can subscribe to eight weekly issues of a newsletter called *100 Highest Yields* (P.O. Box 08888, North Palm Beach, Fla. 33408).

The yield on a CD is what you shop for, rather than the simple interest rate. The percentage yield is higher than the rate because it includes the result of compounding the interest over the term of the CD, if the term is at least a year, or as an annualized yield on shorter-term certificates. The frequency with which interest is compounded—daily, weekly, monthly, quarterly, semiannually, or annually—shows up in the yield quotation.

The more frequently your interest is paid, the higher the quoted yield will be.

But even the quoted yield can be misleading. Other variables, such as whether the bank bases its compounding on a 360-day or 365-day year, affect the yield. The right question to ask in shopping for CDs is this: "If I give you this much money today, how much will I have in the account at the end of the term, after all fees and charges?"

Avoiding wobbly banks

Until this year, the highest yields came mostly from teetering S&Ls in Texas and other oil-patch states. Despite Federal insurance, they are chancy places to put money. The Government guarantees only the principal plus the interest thus far earned. In case of a bank failure, your CD may stop paying that high yield. It may earn you nothing at all until you get your money back.

Happily, it is the sounder, more prosperous institutions in the Northeast that have lately been offering the highest CD yields.

A useful strategy

Even if one-year CDs continue to pay the highest rates, you probably should not limit yourself to that maturity. If rates turn out to be lower a year from now and lower still in two or more years, longer-term CDs will quickly overcome their present disadvantage by paying you higher returns than you could get by reinvesting your money.

No interest-rate forecast is infallible. Thus, a strategy recommended widely by financial advisers is to diversify your money in CDs of several maturities. If rates fall, some of your certificates will continue earning superior yields. If rates rise, your shorter CDs will come due in time to get you in on the higher yields. In short, hedge on rates rather than trying to predict where they're headed.

QUESTION FOR MS. SHEARER FROM SENATOR BENTSEN

In your statement you highlighted some of the insurance sales practices you view as abusive, particularly "twisting" or "churning" (selling a customer an only slightly different new policy instead of renewing his old one because new policies pay higher commissions to agents). Mr. Pomeroy testified that the Commissioners are considering adopting "suitability requirements" which would obligate agents to inquire about a customer's income and need for insurance, and that they are also considering requiring a level commission structure for agents. In your view, will these changes help curb abusive sales practices?

RESPONSE TO SENATOR'S QUESTION

CONSUMERS UNION,
July 20, 1989.

Hon. LLOYD BENTSEN, *Chairman,*
Senate Finance Committee,
U.S. Senate,
Washington, DC

Dear Senator Bentsen: This is in response to your question regarding insurance sales practices, and whether some recent proposals by the National Association of Insurance Commissioners (NAIC) will help curb abusive sales practices.

Consumers Union supports the NAIC's proposed suitability requirement, because it should help to address the problem of duplication of coverage. To aid in enforcement of this provision, we have suggested to the NAIC that the seller be required to ask the individual for answers to the-following questions in writing:

> Does the individual own any other private health insurance policies?
>
> If yes, is the policy a Medicare supplement policy?
>
> Is the individual eligible for or entitled to Medicaid coverage of Medicare cost-sharing, based on income and resources?

We also strongly support the NAIC proposal to level the agents' commission structure. High first-year commissions are the driving force that leads many agents to "churn" their policyholders from one policy to another.

The NAIC has proposed a number of other changes to its model regulation on Medicare supplement insurance. Enclosed is a copy of the testimony which Consumers Union (jointly with the National Insurance Consumer Organization) will present to the NAIC on July 21, 1989.

One other provision of the NAIC proposal deserves special mention. The NAIC proposal would require that every Medicare supplement insurance policy identify separately the amount of the premium for the basic minimum standard coverage, each additional coverage or benefit modification, and the combined total benefits under the policy. This proposal will increase the consumer's ability to compare the prices of alternative policies. While it is certainly a step in the right direction, we do not believe that it goes far enough. We prefer true policy standardization, as enacted in Massachusetts, Wisconsin, and Minnesota. However, if the NAIC decides to use this approach, we have urged it to consider standardizing the riders that can be offered. In our written testimony to the NAIC, we use the example of excess charge coverage to demonstrate the need for standardizing riders to medigap policies. Insurance policies define excess charge coverage in widely varying manners, making rational comparison between policies extremely difficult.

In conclusion, the NAIC proposals regarding suitability and level commissions will be more effective in combating abuses if they are adopted in conjunction with standardization of the market and an intensive consumer education and counseling program.

Thank you for the opportunity to present our views.

Sincerely yours,

GAIL SHEARER, *Manager, Policy Analysis.*

Enclosure.

TESTIMONY OF GAIL SHEARER MANAGER, POLICY ANALYSIS CONSUMERS UNION AND J. ROBERT HUNTER PRESIDENT NATIONAL INSURANCE CONSUMER ORGANIZATION

(Before the National Association of Insurance Commissioners hearing on Medicare Supplement Insurance: Minimum Standards Model Act and Regulation July 21, 1989)

Consumers Union [1] and the National Insurance Consumer Organization [2] appreciate the opportunity to present our views on the proposed amendments to the NAIC Medicare Supplement Minimum Standards Model Act. This market has presented a major regulatory challenge to both state insurance regulators and the Congress for many years now. We congratulate the National Association of Insurance Commissioners for recognizing that the problems continue and need to be addressed by the NAIC and individual states.

In previous jobs, we have both had the privilege to work with Commissioner Gallinger's predecessor as Chair of the Medicare Supplement Task Force, the former Commissioner of Insurance for Wisconsin, Harold Wilde. Mr. Wilde was responsible for establishing a comprehensive medigap regulation in Wisconsin, leading the NAIC into adopting its model regulation, and raising the medigap issue as a matter of great concern to the Federal government.

In our testimony, we will describe the key abuses in the medigap market and provide comments on the seven amendments that have been suggested for the NAIC Model.

OVERVIEW OF MARKETING ABUSES AND MARKET FAILURE

Following the enactment of the Baucus amendment in 1980, there was relatively little publicity about abuses in the medigap market. But, unfortunately, this was not because the Baucus amendment had dramatically improved the performance of the market. The June issue of *Consumer Reports* provides some disturbing information about marketing abuses. The article uncovered examples of agent ignorance, high-pressure marketing techniques, agent efforts to sell unnecessary policies, frivolous variation between policies, and a marketplace characterized by confusion rather than clarity. The article concludes that the Baucus amendment has not cleaned up the Medicare supplement industry. "Sales abuses still abound, misrepresentation continues unabated, and there's evidence that some policies haven't achieved the target minimum loss ratios the [amendment] requires." A copy of the article is attached to our testimony. Some of the key areas of market failure are described below:

1. *Consumer Confusion and Lack of Knowledge.*—The proliferation of policies makes it virtually impossible for consumers to make an informed purchase decision. Research conducted after the enactment of the Baucus Amendment shows that beneficiary knowledge of Medicare and medigap coverage is low. If consumers are misinformed about Medicare coverage, they are likely to be susceptible to sales pitches leading to more supplemental coverage than they need.[3]

2. *Duplicate Coverage/Overselling.*—Some people buy more than one medigap policy, paying thousands of dollars in premiums to buy overlapping, duplicative coverage. Since companies do not tend to coordinate benefits, these consumers are able to collect benefits from all the policies they own. The point here is that uninformed consumers, who are fearful of health care costs, waste their limited dollars by overinsuring.

A 1987 survey by the Health Insurance Association of America found that 19 percent of Medicare-eligible people surveyed owned two or more medigap policies.[4] A

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[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of *Consumer Reports,* its publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports,* with approximately 4 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial, and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] The National Insurance Consumer Organization (NICO) is a non-profit, non-partisan consumer group, established in 1980, that educates consumers about buying insurance and monitors the insurance industry with respect to consumer rights.

[3] Nelda McCall, Thomas Rice, and Judith Sangl, "Consumer Knowledge of Medicare and Supplemental Health Insurance Benefits," Health Services Research 20:6 (February 1986, Part I), pp. 642, 649.

[4] "Medigap Insurance: The Elderly's Experience and Attitudes," Health Insurance Association of American, March 1987.

Health Care Financing Administration study found that 17 to 34 percent of those surveyed (depending on state) owned two or more policies.[5]

3. *Low-Value.*—The General Accounting Office's 1986 results about loss ratios were disturbing. While the Baucus amendment established a target loss ratio of 60 percent for individual policies, the GAO found that 254 of the 398 policies (64 percent) it reviewed had loss ratios below the target. The average loss ratio for commercial medigap policies was only 60 percent.[6] The General Accounting Office's recent report on 1987 loss ratios showed little improvement; 50 of the 91 policies (59 percent) reviewed had loss ratios under 60 percent.[7]

4. *Twisting.*—Twisting is the term used to describe a common agent practice of convincing a client to switch policies. Agents have an incentive to do this since many policies have front-loaded commissions. In other words, the agent earns a hefty commission for first-year premiums, and much less for policy renewals. Consumers often do not benefit from being "twisted" to a different comparable policy, and face increased costs of uncovered charges, since they face new exclusions for pre-existing conditions.

5. *Deceptive Lead Card Company Practices.*—As described in *Consumer Reports,* lead card companies send out mailings to senior citizens, requesting that the recipient fill in and return the card enclosed in the mailing. In many cases, the mailings use names to make recipients think that the sender is a government official. Some of the names include: National Health Information Center; Consumer Referral Service Center, Medicare Division; and Senior Citizens Health Services. Some companies use mailing addresses that are post office boxes in Washington, D.C., to give the impression of a government connection.

COMMENTS ON PROPOSED AMENDMENTS TO NAIC MODEL ACT

Standards for facilitating comparison among policies

Section 8 of the proposed amended Model Regulation would require that every Medicare supplement insurance policy identify separately the amount of the premium for the basic minimum standards coverage, each additional coverage or benefit modification, and the combined total benefits under the policy. This proposal will increase the consumer's ability to compare the prices of alternative policies. While it is certainly a step in the right direction, it does not go far enough. We prefer true policy standardization, as enacted in Massachusetts, Wisconsin, and Minnesota. At a minimum, we urge you to consider standardizing the riders that can be offered, as we describe below.

State Experience with Standardization

Wisconsin led the states into standardization in 1978 when it adopted a rule establishing four distinct categories of Medicare supplement insurance coverage. While the goal of the regulation was to limit variation between policies and to promote consumer understanding, companies gradually undercut this goal by offering optional riders that made it impossible for consumers to rationally compare policies. As a result, Wisconsin recently revised its regulation to end the variation. Policies offered for sale as of January 1, 1989 are required to offer one standard minimum benefits package, with any of six standard riders (including coverage of the Part A deductible, excess charges, and foreign travel) No other benefits can be offered.

In 1980, Massachusetts adopted a "mandatory standardization benefit" approach for regulating the medigap market. The regulation established three levels of medigap coverage. All medigap policies sold in Massachusetts are required to comply with one of the three benefit options and can not be modified. Not only did this lead to a dramatic decrease in consumer complaints, but it also resulted in very favorable loss ratios. In 1986, the General Accounting Office reported that the most popular medigap policy (a Blue Cross/Blue Shield policy) in Massachusetts had a loss ratio of 98 percent, in a market where commercial policies averaged 60 percent and Blue Cross/Blue Shield policies overall averaged 81 percent.

Minnesota recently passed legislation changing its quasi-standardization approach (four minimum levels of coverage, which could be exceeded) to true standardization (two levels, with two optional riders, but no other benefits allowed). The state insurance department had found that the minimum benefit approach led to a proliferation of benefit choices and an inordinate amount of consumer confusion. The law also changes the commission structure to a level commission for the first four years of the policy.

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[5] Report to Congress: *Study of Health Insurance Designed to Supplement Medicare and Oth Limited Benefit Health Insurance Sold to Medicare Beneficiaries,* Otis R. Bowen, M.D., Secret of Health and Human Services (February, 1987).

[6] *Medigap Insurance,* Report to the Subcommittee on Health, Committee on Ways and Means, House of Representatives, October 1986.

[7] *1987 Loss Ratios of Selected Medigap Insurance Policies.* General Accounting Office, April 1989.

We respectfully urge you to consider strengthening the proposed Section 8, along the lines that Massachusetts, Wisconsin, or Minnesota have adopted. We believe that standard policy levels can be designed to provide consumers with meaningful choices that will meet their individual needs. Consumers are not well served by having hundreds of different policies to choose from.

Standaridizing Riders

In the alternative, we urge you to modify Section 8 in order to improve its effectiveness, by standardizing the riders that can be offered. As Section 8 is now drafted, it is conceivable that insurers (overall) will design tens or even hundreds of riders. We recommend that you establish standard language for the riders that can be offered, so that consumers will be able to compare apples with apples, rather than apples with oranges.

The need for standardization of riders was made evident by the recent *Consumer Reports* article's discussion of excess charge coverage. The article found:

> Policies that do cover excess charges cover them in different ways, creating great confusion for anyone trying to compare polices. The excess charge a policy pays is not always the same as the excess charge for doctor bills.
>
> Insurers first define what they mean by excess charge for the purpose of calculating payment. Typically, they define an excess charge not as what the doctor may actually bill in excess of the allowable charge but as the excess charge up to a fixed percentage of the allowable charge. Standard Life and Accident, for example, says an excess charge is any charge up to 80 percent higher than the allowable charge. Other companies define an excess charge as any charge the company deems reasonable and customary. And still others use both limitations.
>
> A policy may then further restrict its payment to a stated percentage of what it has defined as an excess charge. It may pay as much as 100 percent of what it says is an excess charge, or it might pay less. It may also make its payment for excess charges subject to a deductible.[8]

If company A defines excess charge coverage to be 100% of all usual and customary charges above allowable charges, and company B defines excess charge coverage to be 50 percent of reasonable and customary charges up to 50 percent above allowable charges, with a $250 deductible, one must conclude that the consumer will have some difficulty in comparing premiums (and value) of two companies "excess charge" riders. Therefore we urge you to build on the proposed amendment by standardizing the riders that can be offered. It may be that two levels of "excess charge" coverage would be appropriate, one with comprehensive coverage and one with a lower level of coverage. By standardizing the terms, consumers would be able to make a rational comparison between the options available to them.

Renewability

A proposed amendment to Section 7 of the Model Act, "Minimum Benefit Standards," would require that policies be noncancellable or guaranteed renewable for life. We strongly support this proposal. Consumers need to be protected against companies who cancel groups of policyholders who are becoming older, and hence more expensive to insure.

Commission structure

Section 12 "Prohibited Compensation Arrangements" would have the effect of leveling commissions for agents. We strongly support this proposal, because high first year commissions are the driving force that leads many agents to "churn" their policyholders from one policy to another.

Suitability requirement

Section 17, "Standards for Marketing," would require that agents consider the consumer's circumstances (e. g., income and assets, existing insurance) before recommending the purchase of any indemnity and health, health service, or long-term care policy to any consumer over age 65. We support this provision; it addresses the substantial problem of duplication of coverage.

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[8] "Beyond Medicare," Consumer Reports, June 1989, p. 380.

To aid in enforcement of this provision, we suggest that you require that the seller ask the individual for answers to the following questions in writing:

Does the individual own any other private health insurance policies?
If yes, is the policy a Medicare supplement policy?
Is the individual eligible for or entitled to Medicaid coverage of Medicare cost-sharing, based on income and resources?

Reporting multiple policies

Section 19 "Reporting of Multiple Policies" requires insurers to report the names of individuals owning more than one Medicare supplement insurance policy. This provision might help regulators identify some duplication, but we recommend you broaden it to include ownership of hospital indemnity and dread disease policies (so that ownership, for example, of one hospital indemnity and one dread disease policy would be reported). Since many consumers own multiple policies from different insurance companies, this reporting provision will not help regulators identify these consumers. Each insurance department should develop consumer education and outreach efforts to help identify consumers whose duplication problem involves more than one company.

Unfair trade practices

Section 17 prohibits other unfair trade practices such as misrepresentation, high pressure sales, and cold lead advertising. We support these prohibitions.

Penalties

We support the penalties in Section 20 for violations of the insurance code.

Counseling

We urge you to add a provision in the model regulation that would establish a counseling program for consumers of Medicare supplement insurance and long-term care insurance. The Health Insurance Counseling and Advocacy Program (HICAP) in California and Senior Health Insurance Benefits Advisers (SHIBA) in several other states have been extremely effective in eliminating duplicative coverage and advising senior citizens of their coverage and their choices. In addition, state insurance departments should develop buyers' guides and should consider establishing 800 numbers to provide assistance to consumers. Such outreach efforts would not only directly benefit consumers, but would also alert the departments to consumer problems.

Thank you very much for the opportunity to present our views. We look forward to working with you to improve the regulation of this market.

PREPARED STATEMENT OF ALAN P. SPIELMAN

Mr. Chairman, I am Alan P. Spielman, Executive Director, Government Programs Legislation, of the Blue Cross and Blue Shield Association. I appreciate this opportunity to testify before the committee on the effects of the Medicare Catastrophic Coverage Act on Medicare supplemental insurance. Blue Cross and Blue Shield Plans underwrite benefits to supplement Medicare coverage for about eight and one-half million beneficiaries, approximately 42 percent of all beneficiaries who purchase such coverage. About two-thirds of these beneficiaries have individual Blue Cross and Blue Shield coverage, while the rest are covered under group programs.

Our testimony will address four issues:

- Effect of the Medicare Catastrophic Act on Medicare supplemental insurance;
- Recent trends in benefits and rates in Blue Cross and Blue Shield Medicare supplemental products;
- Revisions to Medicare supplemental insurance standards and state enforcement of those standards; and
- Recommendations to reduce duplicative coverage and improve state enforcement of minimum standards.

Effect of the Medicare Catastrophic Act on Medicare Supplemental Insurance

Passage of the Medicare catastrophic legislation in 1988 changed longstanding features of the Medicare program in almost every significant area of coverage. One effect of these changes was to render many of the federal certification standards for private Medicare supplemental insurance -- Medigap -- inappropriate since, starting January 1, 1989, Medicare began paying some costs that Medicare supplemental policies were previously required to cover. The federal certification standards, which incorporate standards developed by the National Association of Insurance Commissioners (NAIC), are known as the Baucus standards, after Senator Max Baucus (D-MT), the sponsor of the 1980 legislation establishing the voluntary certification program.

To address needed benefit changes and prevent duplication, the Medicare catastrophic legislation included three basic categories of changes affecting Medicare supplemental policies. First, NAIC was given 90 days to revise its minimum standards for Medigap policies. Second, the legislation adopted the NAIC's model transition rules to assure that Medigap policies would not duplicate the new Medicare catastrophic benefits. These rules required informational notices to policyholders, the filing of clarifying policy amendments or "riders", and premium adjustments if appropriate. Third, new requirements were added by Congress to better protect consumers.

Because the new legislation provided Medicare coverage for certain expenses that Medicare supplemental policies previously covered, it transferred a liability from the private market to the government. Estimates of the effect of the savings to

Medicare supplemental insurance resulting from the new law vary according to the assumptions that are made about the typical private policy. CBO estimated a $52 a year savings in 1989 to a "prototype" Medicare supplemental policy that covered all Medicare copayments except for the Part B deductible. Health Care Financing Administration (HCFA) actuaries, for purposes of implementation of the employer maintenance-of-effort provision in the new act, estimate the actuarial value of the 1989 Medicare benefit enhancements at $65 per person.

The actual savings to any policy will reflect unique circumstances and these savings may be offset by increases in health care costs, as will be discussed further in this testimony. Thus, as CBO has indicated, it is inappropriate to assume that all Medicare supplemental premiums should fall in 1989 -- rates will, however, be less than otherwise would be the case had the new legislation not been enacted.

Recent Trends in Blue Cross and Blue Shield Medicare Supplemental Products

Blue Cross and Blue Shield Plan Medicare supplemental programs continue to provide consumers with substantial value and a wide range of benefits, typically exceeding significantly the minimum requirements of federal and state law. In 1987, the average loss ratio on Blue Cross and Blue Shield Plan non-group Medicare supplemental products was 95.3 percent, substantially in excess of the 60 percent minimum loss ratio standard.

With respect to benefits, in 1986 -- the last year for which we have survey data -- 88 percent of Plan non-group Medicare supplemental products covered Part B expenses beyond the $5,000 minimum required under the Baucus Amendment, 84 percent of products covered each hospital deductible, 86 percent covered Skilled Nursing Facility copayments and 63 percent covered the $75 Part B deductible. In addition, 43 percent of our products included coverage for prescription drugs, 36 percent covered Skilled Nursing Facility days after expiration of Medicare benefits, and 29 percent included vision care coverage.

In 1986 almost half of all Blue Cross and Blue Shield Plan products provided some protection against physicians' fees in excess of Medicare's allowed charge or "balance billing" amounts. In some cases, Blue Cross and Blue Shield Plan programs also provided benefits such as wellness education, psychiatric benefits beyond Medicare, and convalescent homemaker services. Even after eliminating coverage for which Medicare now pays, we believe most Blue Cross and Blue Shield Plans continue to provide a broad scope of benefits and represent a solid value for consumers.

Indeed, most Blue Cross and Blue Shield Plan benefit changes since the enactment of the Medicare Catastrophic Coverage Act fall into two categories: 1) clarifying policies so that subscribers understand that Medicare will now cover certain benefits previously covered by the policy, and 2) providing enhancements to benefits which do not significantly increase premiums. These benefit enhancements include wellness programs incorporating health risk assessments, vision care benefits including discount arrangements on eyeglasses and contact lenses, and dental benefits. In addition to these policy changes, we have initiated outreach efforts with the senior citizens' community to help explain the effects of the new law on Medicare supplemental insurance.

The other area in which change has occurred is in premium rates. There are many factors that go into rate adjustments. One factor is when the last rate increase went into effect. Some of our Plans have not had any rate adjustments in a few years, resulting in several of our Plans paying out more in benefits each year than the amount collected in premiums from policyholders. Other factors include the general increases in health care costs and overall utilization by Medicare beneficiaries. For example, in the last decade, total Part B benefit payments have increased at an average annual rate of over 17 percent per year.

As indicated previously, the savings associated with the new Medicare catastrophic law will make Medicare supplemental rates lower than they otherwise would be in the absence of the legislation. Depending on the unique situation of each Medigap product -- its benefits, enrollment, cost trends, and prior rate adequacy -- these savings can enable Plans to decrease rates, hold rates constant, increase rates at a more moderate pace, or improve coverage.

In a recent survey of Blue Cross and Blue Shield Plans, we found that the average annualized premium rate change for our non-group Medicare supplemental subscribers since July 1, 1988, the date of enactment of the Medicare Catastrophic Coverage Act, was about an 8 percent increase. Of the 116 Medicare supplemental products for which data were obtained, 88 had rate increases, 20 had decreases, and rates for 8 products were unchanged. Some Plans were able to make across-the-board adjustments to all of their Medicare supplemental products -- such as Blue Shield of California, which reduced all rates by $2.00 per month -- while other Plans had different rate changes for different products.

Revisions to Minimum Standards and State Enforcement Efforts

During your consideration of the catastrophic coverage legislation, we urged that you rely on the NAIC to revise its minimum Medigap standards to reflect the changes that would occur in Medicare coverage and increase consumer protections in the marketplace. Your adoption of this approach was well-founded.

The NAIC acted promptly to revise its model minimum standards for Medicare supplemental insurance within 90 days following the enactment of the Medicare Catastrophic Coverage Act. In this effort, state insurance regulators balanced the objective of comprehensive insurance coverage with the practical necessity of keeping Medicare supplemental insurance premiums affordable. The issue of affordability was particularly relevant in light of the significant increases in premiums -- both flat and income-related -- that beneficiaries must pay for the new Medicare catastrophic benefits. The result, which the Blue Cross and Blue Shield Association strongly supported, is a new set of minimum NAIC Medigap standards which we believe respond to consumer and Congressional concerns about providing worthwhile private supplemental benefits.

The NAIC is now considering a number of proposals to strengthen the consumer protection provisions of its model minimum standards act and regulations. These proposals include specifying for potential buyers the premium applicable to the minimum standards coverage portion of the policy, providing buyers with information on complaints filed with the insurer, limiting agents' commissions to discourage the frequent replacement or "churning" of Medigap policies, and establishing new standards for marketing. We support the general thrust of these proposed changes and are currently analyzing them in detail to provide comments to the NAIC at its July 21 hearing on this subject. We would be pleased to provide the committee with a copy of these detailed comments when they are submitted to the NAIC. Once the NAIC completes this work, we would urge the Congress to review the changes for possible incorporation into the federal certification program.

Minimum standards and consumer protections, however, can only be effective if they are enforced by state departments of insurance. We believe that states generally have done a good job in enforcing the original Medigap standards. A 1986 GAO study of the Baucus standards also concluded that states have relied on a variety of means such as monetary penalties, cease and desist orders, and agent licensure revocation or suspension when appropriate to safeguard consumers. However, we recognize as have GAO and others that there have been problems in specific sales practices that need to be addressed. We believe that Congress can further encourage adequate state enforcement and provide incentives for states to devote needed resources to consumer protections by expanding federal oversight of states' efforts to prevent the sale of substandard Medigap policies. Our specific recommendations in these areas are discussed below.

Legislative Recommendations

We believe that seniors who purchase additional insurance coverage to supplement their Medicare benefits should have confidence that their policies provide worthwhile benefits at a reasonable cost. We also believe that more needs to be done to reduce wasteful consumer spending for multiple policies of marginal additional value. There is no reason for seniors to buy more than one certified Medigap policy.

In addressing these issues, we would urge you to continue to look to the NAIC and the states to fulfill the important responsibilities of standard-setting and enforcement of Medigap insurance standards. The federal government, as it did in enacting the 1980 and 1988 amendments in this area, should play a supportive role by encouraging the establishment and operation of effective state regulatory programs, establishing federal penalties for certain abusive marketing practices, and assisting in consumer education.

Should the committee decide to proceed with changes to the federal law provisions affecting Medigap, we recommend that you focus on reducing unnecessary insurance coverage and on encouraging proper state enforcement of existing standards to ensure that consumers receive proper value for their premium dollars.

Our recommendations are twofold:

1. Reducing Duplicative Coverage. In order to reduce duplicative coverage, we propose, prior to the sale of an individual health insurance policy to a Medicare beneficiary, that the buyer be given a clear statement approved by the state insurance commissioner comparing how the policy measures up to the Medigap minimum standards. This notice would also inform consumers of the availability of Medicaid coverage of Medicare cost-sharing for low income persons. Finally, it would clearly advise the consumer that buying more than one policy that meets the minimum Medigap standards is unnecessary.

We propose that insurers be required to obtain a signed statement from the buyer that the required information had been provided. Failure to obtain this signed statement would subject the insurer or agent to civil and criminal penalties.

We also believe that the current federal penalties for knowingly selling seniors duplicative policies should be clarified and strengthened to apply to those Medigap policies that pay benefits without regard to benefits paid by other policies.

2. Improving State Enforcement of Medigap Standards. We also recommend that new procedures be established for states to maintain federal approval of their regulatory programs for Medigap insurance. Specifically, we propose that states provide assurances satisfactory to the Secretary of Health and Human Services that they have mechanisms in place for reviewing the loss ratios of Medigap policies and have taken appropriate regulatory actions against policies which persistently fail to deliver reasonable value to consumers. The Secretary would be authorized to withdraw approval of the state's regulatory program if the state's assurance could not be substantiated.

We believe that these proposals will strengthen federal and state efforts to protect seniors who purchase Medigap without supplanting state regulatory authorities.

Conclusion

The provisions of the Medicare Catastrophic Coverage Act are sufficient to assure that Medigap policies do not duplicate the new Medicare catastrophic benefits. The new law will result in savings to consumers for their Medicare supplemental insurance costs, generally by lowering the amount that premiums otherwise would be increased in the absence of the expanded Medicare benefits. However, health cost inflation and utilization are expected to still result in Medicare supplemental insurance premium growth in most cases.

Further efforts to strengthen state regulatory programs regarding Medigap are appropriate. The Blue Cross and Blue Shield organization and other insurers are working closely with the NAIC on proposed changes to its model state law and regulations. We believe that the federal government can support and strengthen these efforts by revising federal law to help reduce unnecessary insurance coverage and by encouraging appropriate state enforcement of existing standards.

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Responses to Questions from Senator Bentsen

QUESTION: Earlier in this hearing, you heard Ms. Shearer from Consumers' Union testify that the Federal Government should "standardize" available Medigap policies, that insurers should be prevented from paying higher commissions for selling new policies, and that the sale of duplicate Medigap policies should be banned. Mr. Pomeroy, representing the State insurance commissioners, advocated a different approach. He wants Federal Medigap standards to require agents to inquire about the "suitability" of a policy for an individual consumer's needs, reporting of multiple policies, and improved consumer information. Mr. Pomeroy also indicates that the commissioners believe that Federal criminal penalties against duplication of coverage need to be revised. Could you comment on some or all of these proposals?

RESPONSE: The Blue Cross and Blue Shield Association (BCBSA) supports continued reliance on standards developed by the National Association of Insurance Commissioners (NAIC) for insurance which supplements Medicare benefits. We are committed to working closely with the NAIC on their current effort to strengthen Medigap consumer protection standards and we believe that Congress should review the NAIC changes when they are completed for possible inclusion in the federal voluntary certification program.

Our position on various provisions being considered by the NAIC is summarized below:

Duplicate Coverage: In our testimony of July 21, 1989 before the NAIC Task Force on Medicare Supplemental Insurance, BCBSA recommended that "current federal penalties for knowingly selling seniors duplicative policies should be clarified and strengthened to apply to those Medigap policies that pay benefits without regard to benefits paid by other policies." We also recommend that seniors be informed prior to purchasing supplemental coverage that it is not necessary to buy more than one policy that meets minimum Medigap standards. Finally, we believe that seniors should be informed of the availability of state Medicaid coverage for Medicare cost sharing which may eliminate the need for additional private insurance coverage.

Suitability: We believe that NAIC's proposal for determining a consumer's suitability for a Medigap product is a sincere effort to eliminate sales of unneeded or costly coverage. While we support the NAIC's objective, we believe that the proposed suitability requirements would overly invade the privacy of consumers by mandating that information be revealed on an individual's income, assests and insurance coverage. We are concerned that such a requirement might create strong adverse consumer reaction to supplemental insurance policies and could aggravate, rather than alleviate, abusive practices by unscrupulous agents.

Reporting of Multiple Policies: The NAIC provision would require Medigap carriers to report multiple insurance policies sold to an individual by the same company. Many Blue Cross and Blue Shield Plans already match subscriber I.D.s and catch inadvertent duplicative policies. However, the marketplace problem as we understand it is with the individual who needlessly purchases multiple policies from multiple carriers. The NAIC provision would not solve that problem nor does there seem to be an efficient means for matching multiple carrier policy information to identify needless policy stacking. We believe that rigorous enforcement of current state laws including detecting and disciplining abusive agent practices would go a long way toward isolating the multiple policy problem. We also believe that NAIC's computerization of agent or broker disciplinary actions from all the states should prove invaluable.

Consumer Information: We support increased efforts to better inform seniors about Medicare supplemental insurance. Presently, insurers provide consumers with buyers guides jointly prepared by NAIC and HHS. In addition, seniors are given outlines of Medicare and Medigap coverage, required disclosure notices on policies, information on how to locate state insurance departments and a federal toll-free line for questions on catastrophic coverage. Still, we believe that more can and should be done to better inform consumers about their insurance needs and purchases. We recommend that increased emphasis be given on providing information to prevent unneeded, duplicative coverage and on sources of assistance for making informed decisions about supplemental coverage.

Agent Commissions: Last year the Blue Cross and Blue Shield Association (BCBSA) supported an NAIC limitation on agent compensation for the sale of new policies, sold by the same company, which are substantially similar to a policy already held by a subscriber. We believe this provision will discourage much of the practice of wasteful policy churning. However, if significant problems persist, we will work with the NAIC to develop additional compensation restrictions.

Standardized Policies: We do not believe that federally prescribed standardized policies are in the best interest of consumers. Indeed, we believe that the overwhelming number of consumers have benefited from innovative policies which have been developed to meet different insurance needs in different parts of the country. Since the enactment of the Medicare catastrophic benefits program, many of our Plans are seriously examining how best to respond to changing senior insurance needs and many plan to offer benefits such as vision and dental care and health promotion/disease prevention coverage. Strict standardization might preclude such worthwhile changes in Medigap policies and stifle creative efforts to identify and respond to the changing needs of seniors.

QUESTION: In your statement, you have a proposal to deal with findings by the General Accounting Office that some Medigap policies fail to meet the Baucus target loss ratio standards because they do not return a sufficient percentage of premiums in the form of benefits. You propose that States be required to put in place mechanisms for reviewing actual loss ratios and that they be required to take appropriate regulatory action against policies which persistently fail to deliver reasonable value to consumers. You do not support direct Federal regulation of actual loss ratios, however, I'd like to draw out a little more detail about your loss ratio proposal. How long would it take between the time a consumer buys a policy that fails to deliver good value and the time the State would take regulatory action?

RESPONSE: The Blue Cross and Blue Shield Association believes that loss ratios, measured over time for mature policies, have generally been good indicators of the overall value of a policy's benefits relative to premiums paid. We are pleased that recent reports by GAO have confirmed our own evidence that Blue Cross and Blue Shield Plans return over 95% of their average premium cost in the form of benefits paid on behalf of subscribers, substantially exceeding the minimum 60% standard for non-group coverage.

Under our proposal, the Secretary of Health and Human Services would have the authority to rescind approval of a state's regulatory program if assurances could not be substantiated that mechanisms are in place for reviewing Medigap loss ratios and that appropriate action has been taken against policies which persistently fail to deliver reasonable value to consumers.

Our proposal builds on the Senate provisions included in the Medicare Catastrophic Coverage Act which require insurers to report their actual Medigap loss ratio performance to state commissioners based on NAIC standards. It also maintains the balance between the federal role in establishing minimum standards for Medigap insurance and the states' traditional responsibilities for regulating insurance products. Our expectation is that our proposal would further encourage states to actively monitor Medigap loss ratio data on an annual basis and notify insurers when a policy fails to meet minimum performance standards.

Consumers might benefit from state regulatory action at various times depending, in part, on the length of time a policy has been sold and the size and relative stability of the pool of subscribers. For a stable policy which has been marketed for several years and has failed to meet loss ratio standards, state actions such as lowering premiums or mandating refunds would directly and immediately benefit all subscribers. In contrast, for a new policy we would expect that initial loss ratios for the first two to three years would not yet be reliable indicators of a plan's value. During this start-up period, we expect that state regulators would be more likely to monitor further performance of a policy rather than impose sanctions.

Since there are many variables affecting the amount of benefits a policy pays relative to its costs, such as unexpected changes in claims filed, changes in prices or fluctuations in the utilization of services, we would not expect performance of a policy to be judged strictly on its loss ratio in a single year. One approach, which we have suggested in the past to the NAIC, would be to measure loss ratio performance based on a three-year rolling average which would indicate the value of a policy over time. We would expect that such measures could be incorporated into the Secretary's standards for determining whether state actions to enforce loss ratios have been sufficient.

Finally, we believe that there would be a positive sentinel effect on insurers to increase low value products to at least state minimum standards since companies would be aware that state regulators would be more rigorously enforcing loss ratio requirements. Ultimately, a marketplace which gives consumers greater assurance that their premium dollars will return a solid insurance value is, in our view, one of the best protections seniors can have when they purchase supplemental coverage.

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COMMUNICATIONS

STATEMENT OF THE AMERICAN MINING CONGRESS

The American Mining Congress is an industry association representing all segments of the mining industry. It is composed of (1) U.S. companies that produce most of the nations metals, coal, industrial and agricultural minerals, (2) companies that manufacture mining and mineral processing machinery, equipment and supplies, and (3) engineering and consulting firms and financial institutions that serve the mining industry.

We appreciate this opportunity to comment on S. 771, the Oil Spill bill. As introduced, S. 771 would, in general, disallow deductions for any applicable oil spill or hazardous substance cleanup costs. The bill does allow for two exceptions to the general prohibition of tax deductions for cleanup costs. The first exception would require a company to obtain Environmental Protection Agency (EPA) or U.S. Coast Guard "certification" that the company's cleanup work was a "good faith effort" to comply with applicable Federal cleanup requirements. The second exception would be if the discharge was caused by (1) an act of God, (2) an act of war, (3) an act or omission of a third party, or any combination of the aforementioned.

The American Mining Congress believes that S. 771 will cause far more damage to the environment than it attempts to prevent by creating perverse incentives that will promote the very behavior and actions it seeks to prevent. In addition, AMC believes the bill promotes unsound tax policy and is an inappropriate use of the tax code. AMC urges the committee to reject S. 771.

AMC believes that S. 771 will actually harm the environment by causing unnecessary delays in hazardous waste cleanup efforts. In many cases, prompt action is needed to contain a hazardous waste discharge. However, rather than encouraging prompt cleanup action, the bill creates an incentive for inaction and delay. In order to protect the ultimate deductibility of cleanup and associated costs, companies may wait for specific guidance from EPA or the Coast Guard in order to gain some degree of certainty that a compliance certificate is forthcoming rather than taking immediate action to combat the discharge. Thus, valuable time may be lost in the early stages of the cleanup effort.

Another problem with the bill is the reliance on the ambiguous phrase "good faith effort" when determining if a compliance certificate should be granted. What constitutes a good faith effort to comply with Federal cleanup requirements is subject to a great deal of controversy.

For instance, the Comprehensive Environmental Response, Compensation and Liability Act (Superfund) Section 121 declares that Superfund cleanups shall be done in accordance with "applicable, relevant, and appropriate requirements (ARARs)." We are not certain that anyone understands ARARs any better today than they did two and a half years ago when the ARARs provision was added to Superfund. The end result is more delay as companies and Federal agencies argue about what action should be taken to address the problem.

From a tax policy standpoint, S. 771 is deficient because it (1) challenges the validity of repair and restoration costs as necessary business expenses, and (2) imposes a penalty that will discourage the actions it intends to promote.

S. 771 is a major departure from long standing tax policy of allowing deductions for necessary business expenses. Cleanup costs associated with the accidental discharge of hazardous waste are conceptually no different than repair or restoration of other types of damaged property which are properly deducted as necessary and ordinary business expenses in determining taxable net income. Clearly, the cleanup of an environmental accident is a necessary, albeit unfortunate, cost of producing income and should remain deductible in full.

The loss of a deduction for cleanup costs is a severe penalty. It actually creates a perverse incentive for firms to spend as little as possible to combat a discharge and/or to delay action until detailed guidance is obtained from the appropriate agency in order to protect the deductibility of the cleanup costs. This is exactly the opposite of the behavior that the bill intends to promote.

Another unintended consequence may be the stifling of new and innovative approaches to combating hazardous waste discharges. Why should a responsible party take a chance on a new method or technology, thus risking not being able to convince a government agency that the innovation is truly a "good faith effort?"

The bill is an inappropriate use of the tax code because it intends to serve as another enforcement tool for environmental laws. Penalty provisions of the code should properly focus on encouraging compliance with tax laws, punish non-compliance with those laws and not stray into other legal areas. Enforcement of environmental laws should properly be dealt with in the underlying environmental statutes.

Environmental laws such as Superfund contain penalty provisions, both civil and criminal. If these provisions are deemed inadequate for the task, then those deficiencies should be addressed in those laws and not by tampering with the Internal Revenue Code.

The bill would create new problems in that it involves non-tax agencies in the determination of tax liability, thus adding more uncertainty to the Internal Revenue Code. Cleanup efforts can extend well past a taxpayer's taxable yearend. EPA and/or Coast Guard may delay for years (perhaps for valid reasons) in the issuance of compliance certificates and the denial of certificates will be challenged in court. These added problems on top of nearly constant change in tax laws in recent years make it more and more difficult for taxpayers to manage their tax affairs and settle their tax liabilities with any degree of certainty and confidence. This leads to further erosion of the public's confidence in the integrity of the tax system.

AMC appreciates the opportunity to comment on S. 771 and urges the Committee on Finance to reject amendments to limit or deny deductions for costs to clean up discharges of hazardous substances.

STATEMENT OF FREE THE EAGLE

Free The Eagle (FTE) is an independent, grassroots citizens' lobby which works on issues related to economics. Since its founding in 1980, FTE has been supported by over 350,000 Americans from every state in the nation.

Many of our supporters live on a fixed income and remain concerned about our nation and its policies. These concerns are taken very seriously at FTE and we have been given our "marching orders" by our supporters.

As a result of the Medicare Catastrophic Coverage Act of 1988, many senior citizens have been forced into a mandatory program that requires them to fund a health care program that they will never utilize.

Their mandatory participation in the catastrophic program denies them of highly valued freedoms. Not only is this tax unwarranted, the program does not allow them to choose what kind of health coverage they want. It forces them to fund a government-induced program while at the same time paying for comparable coverage they have obtained through the private sector.

To this date we have received over 4,000 petitions from our supporters demanding that the surtax be rescinded. I know that members' offices have been swamped by anti-surtax mail on this issue.

One of the ironic byproducts of the Catastrophic Health Insurance bill is its unfair taxation of the elderly in four major ways.

First, the over-arching problem of the Medicare Catastrophic Coverage Act of 1988 is the fact that the program is mandatory. Senior citizens have no choice on whether or not to pay for the coverage. If a senior citizen is enrolled in Medicare Part B and over the age of 65, that person is required to pay for the coverage.

Second, the Act of 1988 forces many of its beneficiaries to duplicate health coverage they already possess. Seventy five percent of the elderly currently have Medigap private insurance policies that offer full catastrophic coverage. These people are now being forced to pay ever-increasing taxes and fees for services they have already paid for through other plans. They are being forced, in an unjustified manner, to subsidize a Federal program that they will never need.

Third, the legislation provides for a mandated increase in the surtax over the next four years. The current 1989 surtax rate of 15 percent is subject to a limit of $800 per beneficiary, or $1,600 per couple. Next year, senior citizens will be faced with the burden of producing an additional 25 percent when income tax time rolls around in April. Furthermore, this surtax will increase to 28 percent by 1993, with an apex of $1,050 per beneficiary or $2,100 per couple. After 1993, the surtax is subject to annual increases to adapt to the new Medicare catastrophic health benefits adopted in 1988.

Finally, the surtax imposed by the 1988 Act economically discriminates against the elderly. The Medicare income tax surcharge will raise marginal income tax rates for the elderly above those of other citizens. The surtax will increase marginal tax rates and reduce the real income received on interest, dividend and pension income, and from income received by those who continue to work after they turn 65. Thus, a senior who is working to supplement his pension and social security or saving for retirement is being punished for contributing to the economy rather than living off the earnings of others.

In 1990, the surtax will rise to 25 percent. Where an individual under the age of 65 would bear a Federal tax rate of 15 percent, an individual over 65 in the same tax bracket would bear a Federal tax rate of nearly 19 percent as a result of the tax surcharge. Similarly, a senior citizen in the 28 percent tax rate would be forced to bear an additional 7 percent tax hike in Federal taxes making their marginal tax rate in 1990 approximately 35 percent. The repercussions are even worse for a senior citizen who is required to pay taxes on a portion of Social Security. For the individual, Social Security benefits would cause the 28 percent tax rate to increase to 42 percent, because an added dollar of income makes an additional $0.50 in benefits eligible for taxation.

When the surtax is added on, this tax rate increases to almost 52 percent as a result of taxable income increasing by $1.50 and the tax bill by $0.42.[1]

It is also important to consider the circumstances of those Social Security recipients between ages 65 and 69 who earn enough money at various jobs to suffer the deduction of a dollar of social security benefits for each two dollars they earn. Such a loss of benefits amounts to a preemptive 50 percent marginal tax rate.

But, if one assumes that they are also in a situation where they are subject to the maximum income tax rate, plus the new mandatory catastrophic health tax, the marginal income tax could rise up to 102 percent.

In other words, the 50 percent tax from benefits losses (when earned income exceeds the social security income limits) added to the 52 percent marginal rate resulting from income tax plus the catastrophic health tax totals 102 percent.

Should such an individual go to work and earn an extra $100, he would find that the taxes he pays and the benefits he loses because of that $100 would total $102.

That the Federal Government puts people in such a "Catch-22" situation is asinine. That it idles good workers is criminal; that it makes a farce out of the Social Security has, unfortunately, more than one precedent.

It is for these four specific reasons that FTE feels the tax provisions of the Medicare Catastrophic Coverage Act of 1988 should be suspended and, in the meantime, reviewed to see how the private sector's good alternatives can be made available for those in need. We believe that one alternative would be to make the program voluntary if the private sector could not provide adequate alternatives. Such a program would enable those, who are in need, to take advantage of its benefits.

At the very least, FTE believes that every consideration should be given to legislation introduced by Senator Max Baucus. His bill, titled the Catastrophic Coverage Choice Act of 1989 would give seniors the choice of participating in the Medicare Catastrophic Coverage Act.

No matter how good the coverage is the elderly should have the right to choose their own source of coverage.

Senator Baucus' Catastrophic Coverage Choice Act would create the opportunity to drop the Part B option which caused the duplication of coverage. Those in need of the government program could take advantage of it; those who don't will not be burdened with the added costs.

Second, an optional program would take away the role of the government in deciding what any individual needs, regardless of his own personal circumstances. For some individuals not in a private Medigap policy, catastrophic coverage through the government may be the only option. But it is wrong to make those who have purchased private Medigap coverage pay for another program they will never use.

Finally, making the program voluntary would eliminate a punitive tax on the elderly—a tax that tried to address a problem that was over-anticipated. Here, legislators who wrote the law over-estimated the number of citizens that actually needed to take advantage of the catastrophic benefits. What they failed to account for was that almost 77 percent of our nation's seniors already had catastrophic coverage. As a result, the tax take is higher than needed and the tax burden is unjustified.

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[1] Institute for Research on the Economics of Taxation—July 19, 1989. No. 38.

FTE urges this committee to report out legislation which would delay catastrophic coverage long enough so that a special task force could be established to examine the actual health care needs of the elderly and devise a program that would give catastrophic coverage to those who desire it. At the very least, we urge a reform of the program that would make the catastrophic program voluntary.

The controversy over the Medicare Catastrophic Coverage Act of 1988 is one of timely and significant importance. We thank this committee for opening hearings addressing the inherent problems of this legislation.

STATEMENT OF THE INSTITUTE FOR RESEARCH ON THE ECONOMICS OF TAXATION

The Medicare catastrophic coverage Act of 1988 is poorly understood and contains many controversial provisions. It is a good example of bad legislation, and of why people are better off taking care of themselves than asking Washington for assistance. It should be repealed, and replaced by a return to expanded medigap coverage through the private sector for the majority of the elderly, with financial assistance for the purchase of insurance for those elderly who cannot afford such policies.

HISTORY OF THE ACT

President Reagan asked the Department of Health and Human Services to investigate catastrophic medical costs in 1986. HHS examined three aspects of catastrophic medical expenses: acute care costs for the elderly and disabled (the Medicare-eligible population) relating to temporary illness or injury; long term care costs for the Medicare population, relating to chronic conditions that require some assistance in daily living or lead to long term confinement in nursing homes; and the problem of catastrophic costs incurred by the uninsured of working age or others not eligible for Medicare.

THE REAGAN PROPOSAL

HHS developed a plan dealing only with acute care costs for the elderly and disabled. The proposal would have prevented an enrollee's out-of-pocket expenses for hospital care for acute illness, and associated nursing home care, physicians' fees and outpatient services, from exceeding roughly $2,000 per year. It would have been paid for with a small increase of about $4 or $5 a month in the Medicare Part B monthly premium.

DUPLICATION OF MEDIGAP INSURANCE

In fact, most of the elderly are not unduly concerned with acute care costs. They are more interested in long term care costs, which are much greater and for which less protection is available from private insurance programs. It is important to recognize and understand that the HHS bill, and the subsequent legislation, did not address long term care costs.

At the time the acute care" catastrophic plan was being developed, the majority of the elderly were already fairly well protected. About 70 percent of Medicare enrollees had purchased private insurance to cover much of the acute care costs which Medicare did not pay for. Among those who purchased medigap policies, fewer than one-half of one percent had out-of-pocket expenses over $2,500 per year. Even these higher expenses, generally for prescription drugs and doctor charges above Medicare-approved levels, could have been covered by expanded medigap policies. Indeed, medigap policies were being expanded to cover types of services not covered by Medicare.

In addition, about 10 to 15 percent of Medicare enrollees without medigap coverage were eligible for Medicaid. Under that poverty-related program, the States paid the charges not covered by Medicare.

The group at risk for acute care costs was a portion of the 15 to 20 percent of the elderly who did not buy medigap policies and who were not covered by Medicaid. Even among this group, only about 5 percent had acute care expenses over $2,500 per year, and far fewer had expenses over $4,000 per year.

Some of those who did not buy medigap policies felt themselves to be wealthy enough to cover their medical bills out-of-pocket. Others were not able to afford the policies. It was among this latter group, too poor to buy medigap but not poor enough for Medicaid, that the need for assistance was greatest.

A SIMPLER SOLUTION

The most sensible solution was to provide this group of near-poor with vouchers with which to buy medigap policies directly, or by expanding eligibility for Medicaid to cover the near-poor, while leaving the rest of the elderly alone. Instead, HHS proposed to expand Medicare for all seniors, taking over much of the Medigap business, contending that the government could provide the coverage more cheaply than the private sector. Subsequent developments have made it quite clear that this is far from the case.

GOVERNMENT IS NOT A LOW COST PROVIDER

The contention that government can provide goods and services more cheaply than the private sector is a fiction based on gross misunderstanding of economics and Federal budget accounting. The claim is that the government does not require a profit and has no marketing expenses, and can thus undercut private suppliers. But profit is the service cost of the capital (in this case, buildings, computers, office equipment and reserves) used to provide the service and to cover risk. All these costs are incurred by the Federal Government, but are not counted as program costs in the budget. They are nonetheless borne by taxpayers or beneficiaries in one way or another. The government has the same costs of providing product information to beneficiaries as the private firms. But since government is a monopolist (and further, in the case of health care, may compel people to buy the product) it does not need to advertise and compete with other suppliers. However, this relieves it of the need to be efficient and to tailor its programs to the wishes of its customers, who bear the full cost of this lack of proper service. When all costs, apparent and hidden, are added up, government is the high cost producer in every case where markets could function as alternative suppliers.

Who should pay?

In the original HHS proposal, the catastrophic acute care would have been paid for by Medicare recipients through a small increase in the monthly Part B premium ($4.92 per month according to HHS, $6.40 according to CBO). On the assumption that the elderly wanted acute care coverage, it was decided to make the elderly pay the cost. Part B of Medicare already used a premium, although it did not cover the full cost. It would have been difficult to raise the payroll tax again; there had already been six payroll tax increases since 1980, and there is another one scheduled for Jan. 1, 1990. Furthermore, Social Security payments kept pace with inflation in the late 1970s and early 1980s, and actually outstripped inflation for new retirees in that period, while wages failed to keep up with prices. As a result, per capita income for the elderly, especially the newly retired elderly, began to exceed that of working age families with children to support.

This concept of charging the elderly for their own coverage was fine so long as the benefits went primarily to those who were paying. That is how private insurance works. But that is not what happened in the final bill.

Overcharging the elderly

It is always risky for people to try to buy a product through the government instead of buying it through the private marketplace. Washington always squeezes some benefit for itself out of any action it takes. In this case, congress seized the opportunity to add extra features to the proposal. By the time that Congress was through rewriting the proposal, the bill:

—cost the elderly more, on average, than they could expect to get back in benefits,
—shifted a portion of the nation's welfare burden from the general taxpayer to elderly taxpayers,
—imposed a new tax on the elderly and took much of the revenue to help pay for other Federal spending, and
—raised the health care insurance costs for the elderly as a group.

WHAT DOES THE BILL DO?

Benefits related to Part A of Medicare:

—The Act limits the number of hospital deductibles to one day per year ($564 in 1989) instead of one day for each 60-day spell of illness requiring a new hospital admission. It provides for unlimited hospital days without copayment by the patient. It provides for 150 days of skilled nursing home care instead of 100 days, with only the first 8 days requiring a 20 percent copayment ($20.50 per day in 1989); previously, copayments were required for days 21–100 at higher rates (e.g. $67.50 in 1988). The Act provides unlimited hospice days for terminal patients.

It raises home health care visits to 38 consecutive days, seven days a week, up from five days a week for three consecutive weeks.

—The Health Care Finance Administration estimates that 7.2 percent of enrollees will incur high enough hospital/nursing home costs to receive Part A-related benefits under the Act.

Benefits related to Part B of Medicare:

—Part B of Medicare pays 80 percent of doctors' fees and outpatient charges above a $75 deductible. The copayment by the patient is 20 percent. The bill puts a cap on these copayments of $1370 in 1989.

—The copayment cap will be increased each year such that only 7 percent of enrollees will exceed the limit and receive benefits under this provision.

Catastrophic Drug Insurance plan:

—The drug plan will be phased in between 1990 and 1993, and will eventually cover 80 percent of prescription drug charges above a deductible. The deductible will be $550 in 1990, increasing to $710 by 1993.

—The deductible will be increased each year to keep the number receiving drug benefits from exceeding 16.8 percent of enrollees.

In any given year, only 20 to 30 percent of enrollees will receive benefits under the Catastrophic Coverage Act; between 70 and 80 percent will not.

Proponents of the Act often say that large numbers of enrollees will get higher Medicare benefits because of the Act. This is true, particularly over a lifetime. But this does not mean that enrollees will get more benefits than under previous law, counting both Medicare and medigap benefits. To a large extent, the beneficiaries will receive similar benefits, only from different sources, with Medicare picking up more of the tab, and medigap less.

IMPACT ON MEDIGAP

It is clear from the list of benefits that many of the benefits were already covered by medigap policies. In fact, the Act displaces about two-thirds of the benefits formerly mandated for coverage by such policies. The Act requires that medigap policies be cut back to avoid duplicating coverage provided by the Act, and their premiums reduced accordingly, or that other services be added to the policies. There was no reason for the government to seize this business from the private insurance industry.

It is also clear from the list of benefits that Medicare enrollees will still need medigap policies for significant deductibles and copayments not covered by Medicare, for most prescription drug costs, and for doctors' fees in excess of Medicare-approved levels, much as before the Act was passed.

FINANCING THE MEDICARE CATASTROPHIC COVERAGE ACT

A tax surcharge related to Part A of Medicare:

—All those who are eligible for Medicare Part A, whether they are enrolled or not, will pay a new income tax surcharge to defray part of the cost of the Catastrophic Coverage Act.

—This is being called an "income-related premium," but it is really a tax. It is part of the income tax law; it is collected by the IRS; it is subject to quarterly income tax estimated payments. (The IRS will not penalize taxpayers who forget to include the surcharge in figuring their estimated payments in 1989, but there will be penalties for underestimation of tax beginning in 1990.)

—The surcharge will be 15% of the Federal income tax liability in 1989, 25% in 1990, increasing one percent a year to 28% in 1993. The rate my go higher by up to 1% a year thereafter if the costs of the program continue to rise.

—The surcharge is based on one's tax liability. For example, if one's 1989 Federal income tax without the surcharge is $100, the surcharge is $15, and the total tax is $115. If one's Federal income tax is $1,000 without the surcharge, the surcharge is $150, and one's total tax is $1,150.

—There is a maximum surcharge of $800 for a single taxpayer and $1600 for a married couple in 1989, rising to $1050 (single) and $2100 (couple) in 1993. These maximums may rise thereafter, without limit, if Medicare Part B outlays rise faster than the Part B premiums. (Although liability for the surcharge is related to Part A eligibility, the cost adjustments are keyed off Part B indexes.)

Note that everyone must pay the surcharge if they are merely eligible for Medicare Part A, even if they are not enrolled in it. Every Medicare eligible person must pay even if:

—they are still working and are covered by their employers' health plans rather than by Medicare;
—they are retired, but receive health care as a retirement benefit from former employers, and are not enrolled in Medicare.

A partial exception is the case of retired Federal workers, who get a credit offsetting part of the surcharge to reflect the duplicate health coverage they receive under Federal retirement. This special credit is not available to those with coverage from private employers.

The surcharge revenues will go first to cover the Part A-related catastrophic benefits. Excess surcharge revenues are expected to cover 63 percent of the cost of the Part B-related and prescription drug benefits.

An increase in the Medicare Part B monthly premium:

—For those enrolled in Medicare Part B, the monthly premium will be increased by $4 a month per enrollee in 1989 to cover a portion of the Part B catastrophic benefits. This is $48 per year for a single enrollee, $96 per year for a couple. The additional premium will rise to $10.20 per month by 1993 to pay for increases in Part B catastrophic costs and to pay for the prescription drug coverage as it is phased in. This is $122.40 for a single enrollee, $244.80 for a couple.

The increase in the Part B premium is expected to cover 37 percent of the cost of the Catastrophic Part B and prescription drug provisions. The remaining 63 percent will be paid for with part of the surcharge.

Those who are not enrolled in Medicare Part B may avoid this premium, but are not eligible for any of the Part B and drug benefits, even though they are paid for mostly by the surcharge. Those who find they need the coverage may join Part B during their annual enrollment window.

IMPACT OF FINANCING MECHANISM ON WHO PAYS

The shift of many services previously covered by medigap from private to Federal control has greatly redistributed the burden of payment. Previously, the medigap policy buyer paid for his or her own coverage. Medigap buyers paid only for what they thought they needed and what they thought was worth the price.

Now, many of the elderly who were buying medigap are being forced by the Catastrophic Coverage Act and its income tax surcharge to buy a fixed package of benefits not tailored to their needs, and to pick up the tab for many lower income Medicare enrollees who were previously not buying medigap coverage. This lower income coverage was previously funded primarily by the general taxpayer, and constitute a portion of the welfare transfers within the Federal budget. Welfare spending is an obligation of the whole country, and should not be imposed on a narrow subset of taxpayers. Yet this bill shifts a portion of Federal welfare spending from the general taxpayer to the elderly taxpayer. In addition, the Act disproportionately benefits nonelderly Medicare beneficiaries who are receiving coverage under Social Security Disability Insurance or under the end stage renal (kidney dialysis) program, programs whose costs are usually spread more broadly through the payroll tax.

The Catastrophic Act does not stop there, however. In addition to reallocating the actual cost of the Catastrophic program among beneficiaries, it proceeded to overcharge for the program as a whole. The surcharge and premiums are set high enough to generate a substantial surplus of revenues over outlays for the first several years of the program. The congressional Budget Office originally estimated a surplus of more than $4 billion between 1989 and 1993, and has since raised the estimate to about $10 billion. The Administration projects a four year surplus of just over $6 billion. An IRET study estimates the surplus at nearer $16 billion. These extra funds will go to finance other Federal spending, and to hold down the amount of borrowing the Federal Government will have to do to pay for the rest of the budget.

No wonder that the CBO reports that many middle and upper income Medicare eligible taxpayers will see their total health care costs rise by more than their benefits. Elderly taxpayers with non-Social Security income of more than $9,500 (single) and $17,500 (married couple) will find that their income tax surcharge and premium increase will exceed the benefits they may expect to receive from the Act. In other words, for them, the insurance coverage under the Act will not be worth the cost. It is not the sort of "insurance" they would voluntarily buy from the private sector.

ECONOMIC IMPACT OF THE SURCHARGE.

An added problem with the surcharge is what it does to the tax rates of senior citizens. A surtax drives up the marginal tax rate on interest, dividend and pension income, and on income from wages for those who are still working. This punishes those who saved for their own retirement, or are earning extra income to supplement pensions and Social Security, and who are contributing to the economy instead of being dependent on the earnings of others.

When the surcharge reaches 28% in 1993, it will effectively make the 15 percent tax rate seem like 19 percent (15 x 1.28=19.2) and will make the 28 percent tax rate seem like 36 percent (28 x 1.28=35.84). If the taxpayer is also beginning to pay tax on a portion of his Social Security income, the effect is even worse. The benefit taxation makes the 28 percent tax rate effectively 42 percent, because an added dollar of income makes an additional $0.50 in benefits taxable. This raises taxable income by $1.50, and the tax bill by $0.42. The surtax drives that rate to nearly 54 percent (42 x 1.28=53.76).

These higher tax rates discourage saving and work effort by the elderly. They also discourage saving by younger people who are looking ahead to retirement. What is the point of saving for retirement if the rate of tax imposed on the income from saving is prohibitively high? All of this is hard on the economy, especially at a time of great concern over the country's low saving rate, our borrowing from abroad, our trade deficit and our ability to compete in the world.

ACT SUPPORTERS RAIL AT ELDERLY

Those who support the Catastrophic Coverage Act have expressed outrage that anyone should object to the financing mechanism, which puts the cost of the bill on the elderly. They seek to portray the elderly as complaining solely because the cost has not been pushed onto the working-age population via the payroll tax. They declaim the grand-sounding principle that the people who receive the benefits should pay the bill. Who could object to that? But this is a most disingenuous twisting of words.

The fact is, those who are paying for the Act are not receiving commensurate benefits, and many who will pay little or nothing will receive benefits far in excess of what they pay for. In addition, this is not a voluntary purchase, but a mandatory Federal program.

The true situation is this: if one goes into a restaurant and orders a steak dinner, one expects to pay the check; if one is on the way to a restaurant and a steak dinner, but is abducted by an over-zealous street missionary, dragged to a soup kitchen, strapped down and force-fed a gallon of gruel, and then has the price of a steak dinner snatched from one's wallet to support the mission's good works, one might be intensely and justifiably annoyed.

The original Reagan proposal, while mandatory, at least treated all of the elderly alike. It was financed by a premium of a few dollars a month, which all participants would pay. This, although unfortunately mandatory, at least was similar to the private sector to the extent that everyone would pay the same "price" for the "product" with no discrimination by income. That is the situation in any private-sector shop for goods of all types; you pay the cost to the economy of the product you consume.

By contrast, under the CCA, the "price" for the same service varies according to income, which means according to whether the Congress views one as "deserving" or "flush." No one under the CCA pays for his own coverage only. Either one pays less than the cost of one's own coverage and gets more than one has paid for, or one pays for one's own coverage and someone else's. Even if this were to balance out across the elderly as a group (instead of the actual aggregate over-charging) it would not be true for any individual in the group that he was paying for what he was getting. Those who have come out on the short end of the deal are right to be angry.

The problem is that Washington regards the elderly as a group instead of as people. The elderly are not a group. They are more than 30 million individuals. They have not voluntarily joined a commune in which their assets are pooled for mutual support. They would prefer to do their shopping in the private sector, on a voluntary basis, where they can buy just for themselves, and take or leave a policy and change to another firm at will to get a better price or a better product (holding down national medical costs in the process) Some 70 percent of them were doing this before the CCA intervened. They paid for what they received, and they were willing to do so.

WHAT CAN BE DONE?

Repeal is the answer. The elderly should be allowed to go back to buying less expensive medigap policies. The poor among the elderly should be given vouchers with which to purchase insurance. Alternatively, and somewhat less efficiently, the near-poor could be covered by an expansion of Medicaid.

The Catastrophic Coverage Act is a good example of what can go wrong when the government intrudes into a functioning private market. What was basically a welfare problem for a small portion of the elderly was inaccurately defined as a much broader problem, leading to a program which covered all of the elderly and which served as a means of raising revenue via a most peculiar age-related tax. It is doubtful whether such a tax could have been passed without the camouflage of supposedly improved benefits for a large segment of the elderly population. In truth, these benefits are largely non-existent, or available more cheaply through private insurance. It would be well for anyone contemplating a push for Federal assistance in the future to remember what happened under the Catastrophic Coverage Act of 1988.

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